the Canadian Nurse

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MONTREAL

MARCH 1963

HIGHLIGHTS

SERIES

ON

REHABILITATION

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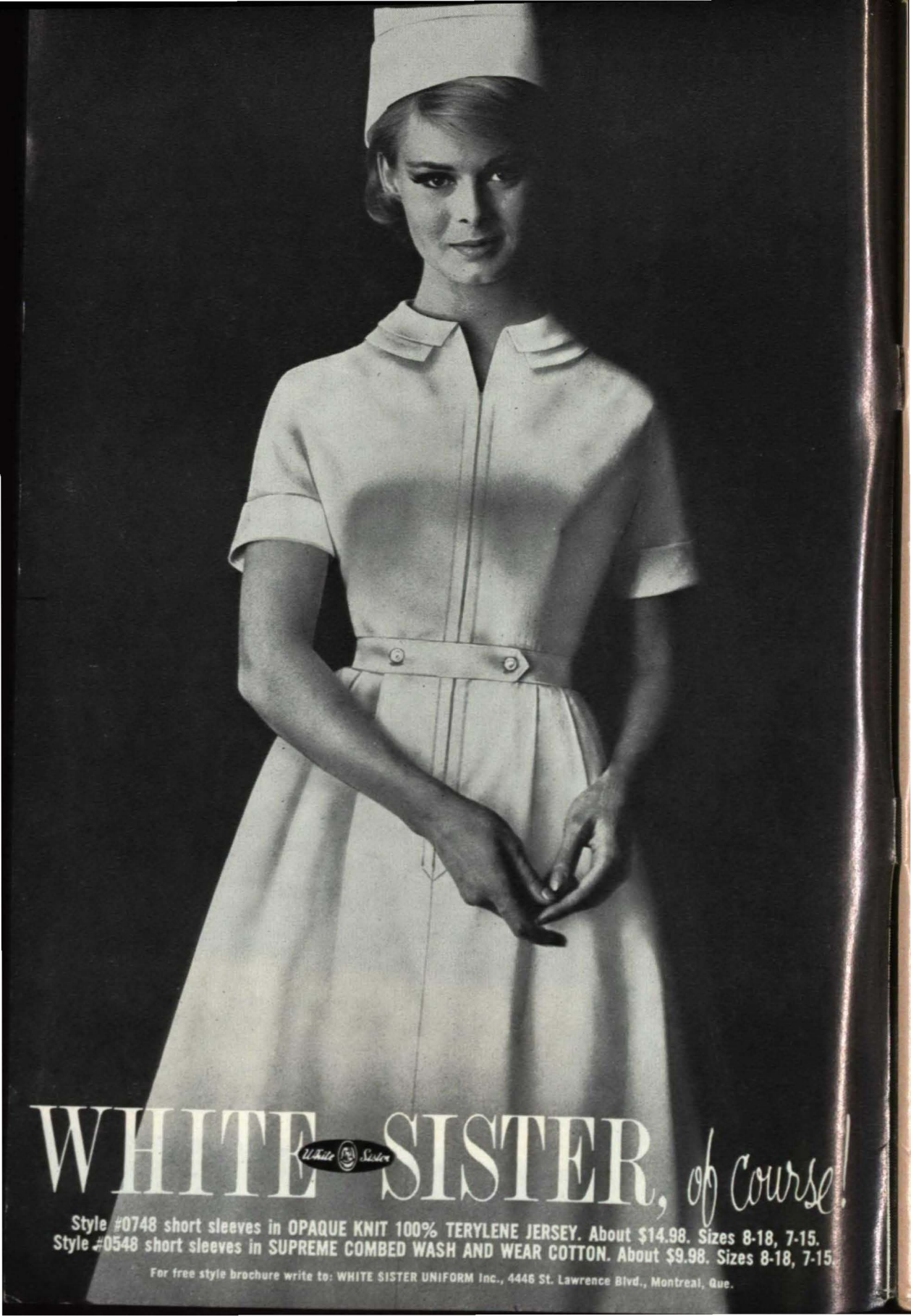
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Between Ourselves

Though it has become a frequent practice to concentrate the majority of the articles in an issue on one particular aspect of professional activity or disease, this is the first time that a single organization has undertaken the rather formidable task of providing such a wealth of information regarding the relationship and function of the nurses on its staff to every department. The organization in this instance is the Rehabilitation Institute of Montreal. The response of the Institute's director, DR. GUSTAVE GINGRAS, to our invitation to provide a broad overview of the program being carried on at R.I.M. was immediate and gratifying. After one conference with our English Editorial Advisor, SISTER MARY ASSUMPTA, Dr. Gingras organized the various personnel to prepare their papers in their preferred language, English or French. Within a month, all of the material was in the *Journal* office!

As noted by several of the authors, rehabilitation, or as it is more aptly termed in French *rééducation*, should be in the minds of all those who care for the sick or injured from the first moment. Over and over again, as you read, you will note that the various specialists remark "the nurse is the one person of the team who is in close contact with the patient." That is true of the graduates and students in every hospital in Canada; it is true of the Victorian Order or the St. Elizabeth nurses giving care to patients in their homes; it is true of the public health nurses in industry, in the schools, in every phase of community life.

What does this "closeness" entail from the point of view of rehabilitation? Another word kept cropping up in many of the articles respecting the nurses' work — *observe*. So many people, not only those who are nurses, "look" without truly "observing." There is a tremendous difference — a difference that is vital to the ultimate rehabilitation of anyone who is ill or injured. Do you merely "look" or do you really "observe"? Think it over.

The Rehabilitation Institute of Montreal is willing and eager to demonstrate the practical aspects of its work to visiting nurses. The next time that you expect to be in Montreal write in advance to the Public Relations Officer, Miss Lachance, for an appointed time to visit the Institute. It is not situated in the immediate downtown area so leave yourself ample time for the trip out there by bus as well as time enough to really observe the broad reeducation program that is described in this issue.

* * *

Once again we are approaching the month when income taxes have to be filed. Those engaged in private nursing can claim a number of deductions that those of us on regular salary cannot. But there is one deduction that every nurse in Canada could make if she wished to. Apparently a great many of you don't so wish. We have to use the second person pronoun there because all of us in the *Journal* do make these deductions. Of course we are referring to the payments we make on our Canadian Nurses' Association Retirement Pensions.

It is a fabulous way to save money! Even if you are paying into another pension plan, you can enrol privately in Plan A of the CNARP. Supposing the plan in effect in your hospital or organization deducts 5 per cent of your salary each month, you can subscribe up to another 5 per cent in the CNA plan and deduct the combined payments from income tax.

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Few things are impossible to diligence and skill.

— SAMUEL JOHNSON

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of THE CANADIAN NURSE *nor of the Canadian Nurses' Association.*

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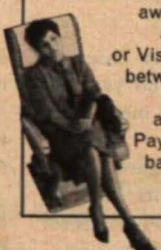

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The Journal presents pharmaceuticals for information. Nurses understand that only a physician may prescribe.

The following recommendations, based on a recent study of patients over 60 years of age, have been made to prevent medication errors in the home:

1. The physician should regard every patient individually, discuss with him his thoughts about his medicines and whatever living problems may have a bearing;

2. The nurse and pharmacist should accept responsibility for transferring the doctor's original counsel;

3. Pharmacists should use larger type on labels and include dosage and frequency; (Not "take as directed.")

4. Visual aids, pictures of actual pills and capsules could profitably be used in instructing patients.

5. A drug schedule should be drawn up together with the patient when more than one medication is ordered;

6. Imaginative ways must be used to fit the medication schedule into the patients' living habits; ("What do you *always* do *every* day? Take your pills then, too.")

7. The visiting nurse should be brought into the picture whenever the patient's condition, forgetfulness or unreliability deem it wise.

—*Squibb Nurses Notes*, August-September, 1962

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MESSAGE FROM THE ICN PRESIDENT

This message appeared in the ICN News Letter, January 1963

A year has passed. During this year, I have been able to make contact with many of you, thanks to the Committees which have met in London, and to my travels. These contacts, rewarding on the professional level, have been equally rewarding on the human level. They have allowed bonds of friendship to be formed and strengthened, and I thank you for all you have given me by your presence and by your letters.

A New Year is beginning. For the ICN it will be a year of work, and, I hope, a year of joy.

1963 will be a year of work because, in all fields, the work of the ICN has increased, which is a sign of vitality, and the National Associations participate in this work.

1963 will also be a year of joy. We know, indeed, that for various reasons, some of our Member Associations are going through a difficult time, and it is to these associations in particular that we would like to send a message of sympathy and encouragement. But the New Year will bring us the happiness of a meeting between the representatives of ICN members. In a few months, we shall meet again in Geneva for a week of work together.

Work and joy, joy in work — that is my wish for each one of you, and for each of your Associations, on the threshold of this New Year.

ALICE CLAMAGERAN, PRESIDENT

Random Comments

Dear Editor:

I would like to thank you for the monthly publication of *The Canadian Nurse*. As Canadian nurses, we should be proud to have such an informative journal.

We are prone to criticize more than praise. Criticism is good since this is how we learn. Those who criticize (the *Journal*) however, should remember that they are members of the C.N.A.; they should ask themselves this question: "Am I doing all that I can to help the editors and my professional associations? — or am I content to let others carry my load?"

Thank you, editors and staff, for a job well-done.

C. DIANNE DAVIDSON, Alberta

Dear Editor:

In the November 1962 issue, you asked for opinions regarding the placement of the author's biographical data.

For the reasons outlined by Mrs. Kay in her letter to the editor, my two nursing colleagues and I would like this information *with* the article.

Our sincere thanks to you and your staff for all that you have done and are doing to make this magazine more valuable to us.

MURIEL MCARTHUR, Ontario

¶To date, 12 letters of comment have been received. We need a larger showing than this, out of the 70,000 nurses who receive the Journal, to change the present pattern.

Ed.

Dear Editor:

I was delighted with the "How do you spell that word?" quiz in the December 1962 issue. I had seven wrong which wasn't so bad for an old gal!

A quiz game on different items in the medical and nursing field would be worthwhile to test our knowledge. Here's to more spelling games, quizzes, etc.

E. R., Ontario.

The healthy stomach is nothing if not conservative. Few radicals have good digestions.

— SAMUEL BUTLER

ANNUAL INSTITUTE

Dalhousie University School of Nursing

Miss Aileen Hogan, Consultant, Maternity Centre Association, New York, is to be the conference leader at the Annual Institute — Dalhousie University School of Nursing. The Institute, to be held at the Nurses' Residence, Victoria General Hospital, Halifax, from March 20-22, 1963, will have as its topic "Family Centred Care: Home or Hospital."

"In the rush of technology and the flood of new knowledge in the area of health, we are in danger of losing sight of the patient and his family and their needs." Thus has the conference leader stated the concept underlying the topic for this year's Institute. Miss Hogan will be assisted in the program by local personnel from medicine, nursing, nutrition, social work and a "family."

Those interested in attending the Institute should address enquiries to The School of Nursing, Dalhousie University. The registration fee is two dollars per person; registration numbers unlimited.

Ontario Nurses Please Note

The Ontario Division of The Canadian Red Cross Society has announced that an award of $1,000 is being offered to graduate nurses registered in Ontario. The candidate selected will use it to undertake further preparation in nursing at the degree level. The Ontario Division recognizes a need in the nursing profession for qualified nurses to assume positions of responsibility and provide professional leadership. The award is established to encourage nurses with basic preparation to undertake graduate studies and qualify for senior positions.

Interested nurses should contact The Canadan Red Cross Society, Ontario Division, attention: Miss Elaine Dawson, Director of Volunteer Nursing Services, 460 Jarvis Street, Toronto, Ontario. Applications must be submitted by April 1, 1963.

In 1962, an award of $1,000 was made to Miss May Watanabe of Burlington, Ontario, who is currently enrolled as a predoctoral student in Sociology and Nursing Research at the University of Washington.

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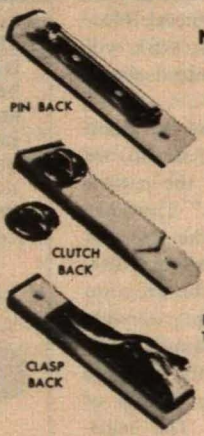

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The National Student Nurses Association of the United States has adopted as *The Nightingale Hymn* the Florence Nightingale Pledge, set to music by Mrs. Mary Campbell for the nursing students at the Itegue Menen School of Nursing of Eritrea, Ethiopia. A very fine nurses' choir presented this at a Students' Convention and it has proved very popular. It is published by the National Student Nurses' Association, Inc., 10 Columbus Circle, New York. The students have secured an international copyright!

— *International Nursing Review*, August, 1962.

The mortality rate during the first half of 1962 was 7.3 per 1,000, compared with 7.2 for the corresponding periods of 1961 and 1960.

Pneumonia and influenza mortality increased 10 per cent over that for the first half of 1961. It decreased 20 per cent below the rate of 28.3 per 100,000 recorded in the first half of 1960.

Mortality from cancer increased one per cent. The death rate from respiratory cancer rose four per cent.

Progress continues to be made in the control of tuberculosis. The death rate established a new low of 5.2 per 100,000; it was 5.6 in the corresponding period of 1961 and 6.2 in 1960.

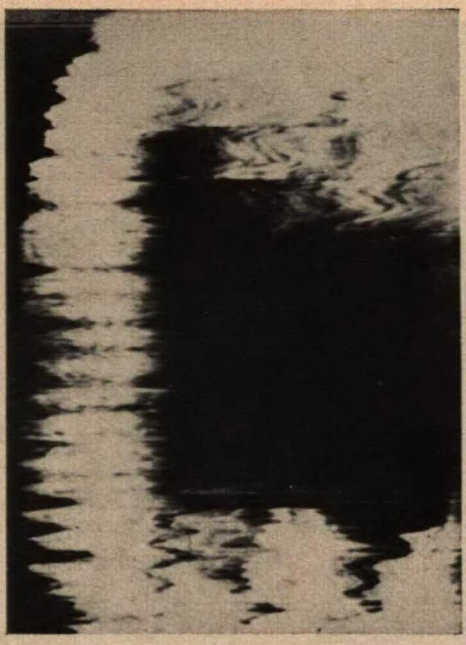
Accidental deaths increased slightly to 32.6 per 100,000. There was a slight decrease in mortality from motor vehicle accidents.

—Metropolitan Life Insurance Co.

* * *

There is no absurdity so palpable but that it may be firmly planted in the human head if you only begin to inculcate it before the age of five, by constantly repeating it with an air of great solemnity.

—Arthur Schopenhauer



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References: (1) Lössl, H. J.: *München. med. Wchnschr.* (supp.) **94**:653, 1952. (2) Birkner, F.: *Wien. med. Wchnschr.* **102**:893, 1952. (3) Bass, E., & Dietrich, H.: *Deutsche med. Wchnschr.* **77**:906, 1952. (4) Schmengler, F. E., & Köster, K.: *Med. Klin.* **47**:121, 1952. (5) Kunz, A.: *Wien. med. Wchnschr.* **103**:305, 1953. (6) Böning, H., & Kirch, A.: *Fortschr. Med.* **70**:351, 1952. (7) Schmidt, J.: *Medizinische* **21**:1293, 1952. (8) Block, A.: *Fortschr. Med.* **71**:202, 1953.

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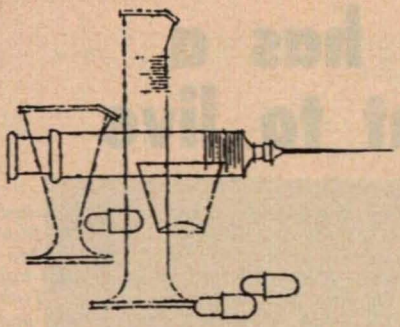

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Instructor in Pharmacology and Anatomy and Physiology, St. Mary's School of Nursing, Rochester, Minn.

Providing nurses with the most up-to-date source material about drugs, the new 9th edition of this noteworthy book still remains the outstanding text in its field. Complete, yet not encyclopedic, it clearly answers the where's, why's and expected outcome of drug therapy. The responsibility of the nurse regarding drugs is clearly stated and well emphasized. Material on Canadian drug legislation and preparations listed in the British Pharmacopoeia will be of special interest to your classes.

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All parts of the book which have undergone revision have been submitted to a leading pharmacologist and educator for his criticism, correction or revision. To keep the text thoroughly up-to-date we will continue to publish an annual supplement. This is given without charge to all those who have purchased the text.

By ELSIE E. KRUG, R.N., M.A., Instructor in Pharmacology and Anatomy and Physiology, Saint Mary's School of Nursing, Rochester, Minn. Ready this month. 9th edition, approx. 812 pages, 6-½" x 9-½", with 45 text illus. and 8 color plates. Price $6.95.

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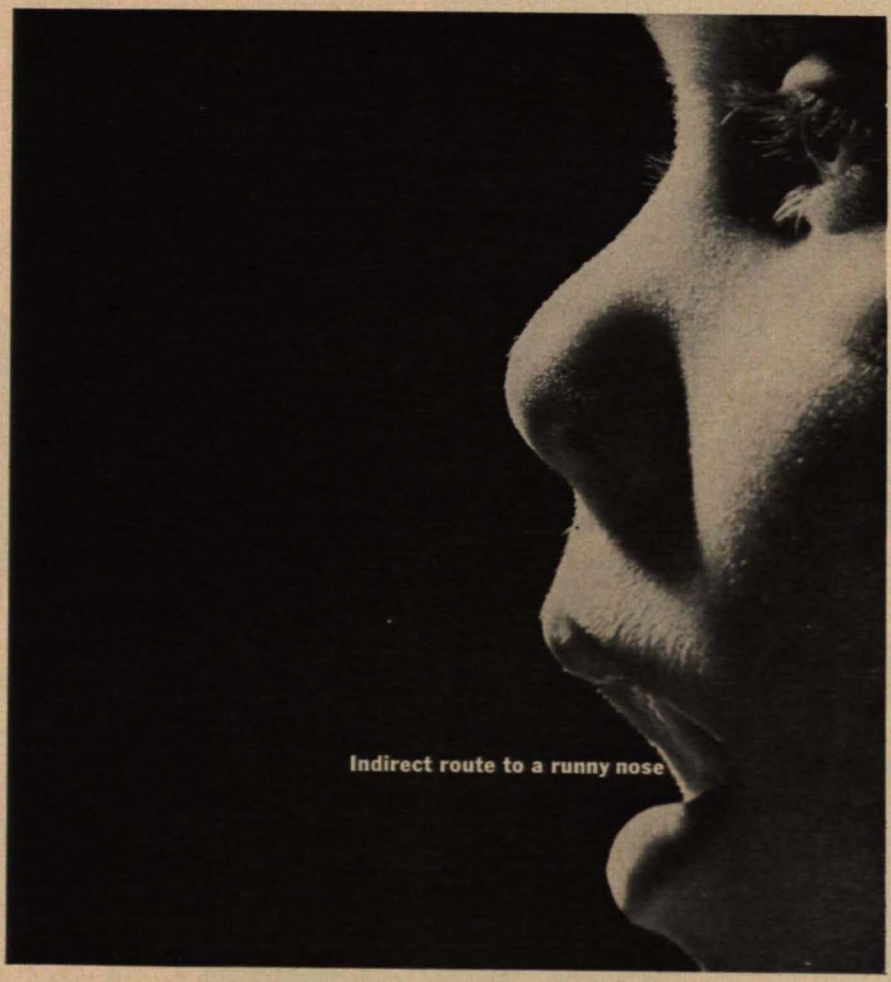

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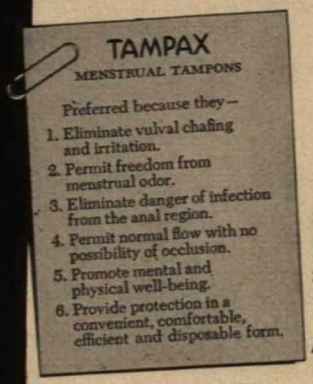
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1. Dickinson, R.L.: J.A.M.A. 128:490 (June 16) 1945. 2. Brand, E.N.: Brit. M.J. 1:24 (Jan. 5) 1952. 3. Magid, M.O., and Geiger, J.: M. Rec. 155:316 (May) 1942. 4. Thornton, M.J.: Am. J. Obst. & Gynec. 46:259 (August) 1943.

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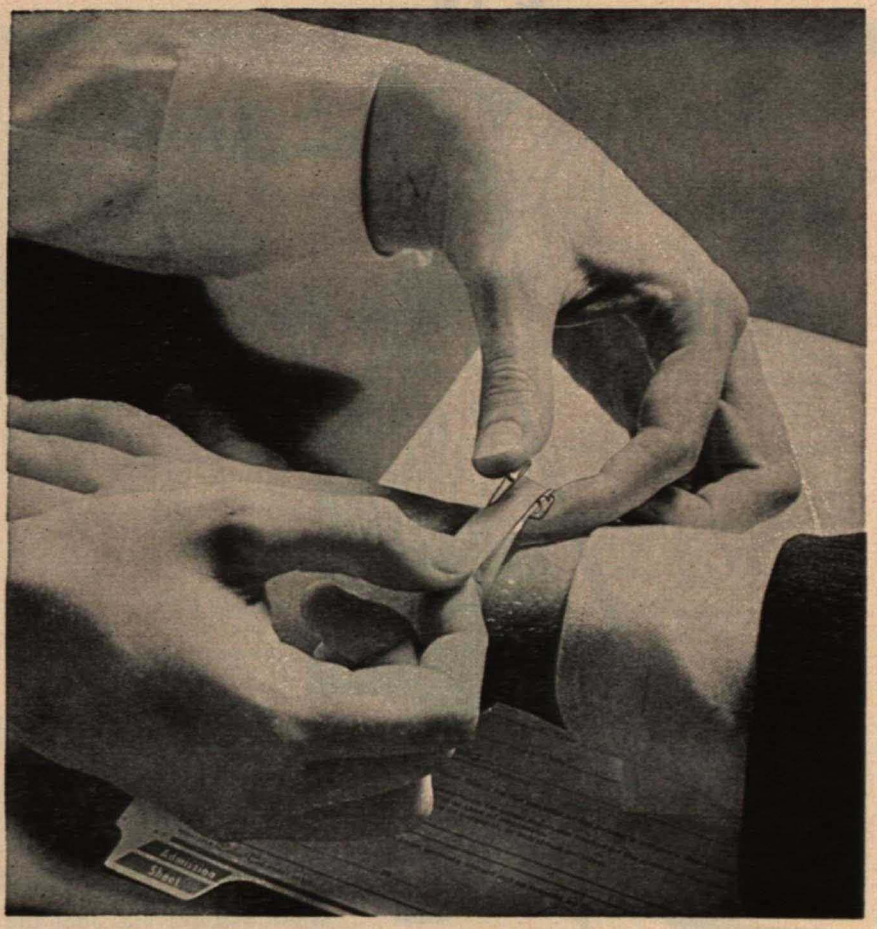

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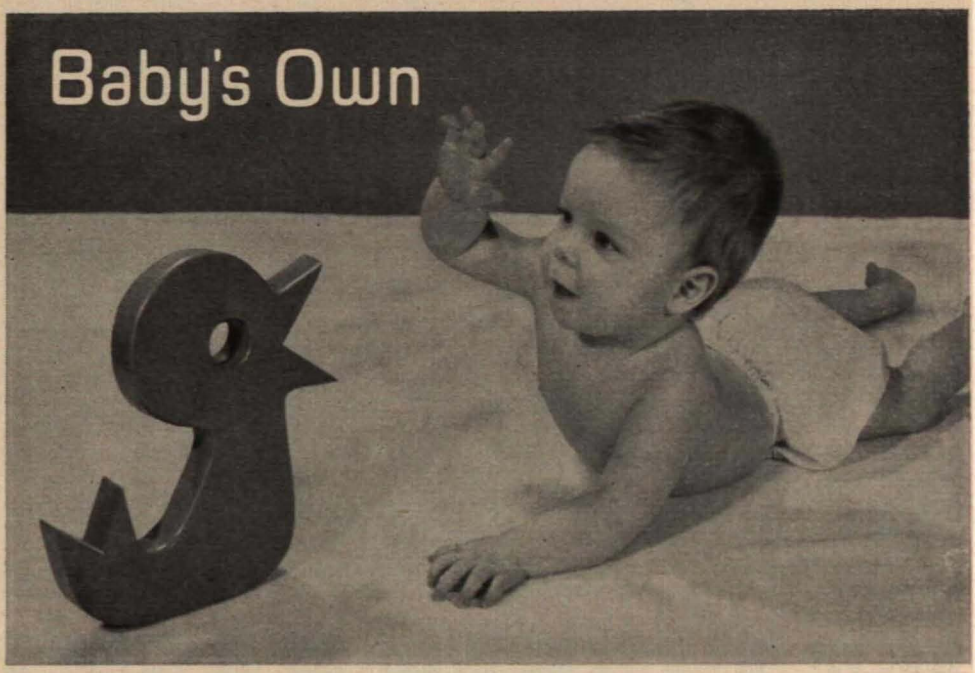

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VOLUME 59 MONTREAL, MARCH 1963 NUMBER 3

Rehabilitation

The investment in rehabilitation is an investment in the greatest and most valuable of our possessions, the conservation of human resources. BERNARD M. BARUCH

It was with great interest and in a spirit of cooperation that the staff of the Rehabilitation Institute of Montreal has prepared a series of short articles dealing with the various aspects of rehabilitation within a specialized centre.

The Canadian Nurses' Association and the editorial staff of *The Canadian Nurse* are to be highly commended for their interest and vision concerning what seems to be one of the most important psycho-social and medical problems of this century: rehabilitation. The term as used throughout the series may be defined as a treatment process applicable not only to recent victims of trauma or sickness but also to chronically ill and geriatric patients in order to achieve maximum recuperation and/or health maintenance in these ever-increasing segments of our population.

The rehabilitation process in a rehabilitation hospital would be utterly impossible wihout the full participation and contribution of the nurse or without her total understanding of the various treatments and procedures carried out in the different treatment and investigating departments. It is heartwarming to note that the Institut Marguerite d'Youville and the School for Graduate Nurses of McGill University have included lecture-demonstrations and field visits to rehabilitation organizations to keep abreast with current trends. No doubt this will emphasize the importance and necessity of adding, shortly, a course on rehabilitation to the curriculum of teaching schools of nursing. It is hoped that the next step

forward will be that student nurses spend a period of their training in Departments of Physical Medicine and Rehabilitation of general and special hospitals.

The era when nurses did everything for the patient, even when confronted with an excellent rehabilitation prognosis, is long past. It is imperative that the nurse be a moderator and a teacher of methods, which through cooperation and collaboration with all those who devote their lives to the welfare and care of human beings, will restore her patient to as normal life as possible in the society in which he lives and thus add dignity and happiness.

GUSTAVE GINGRAS, M.D.

REHABILITATION AND THE NURSE

BERTRAND PRIMEAU, M.D.

Where does the registered nurse with her training in curative skills fit into a rehabilitation program?

Among the human rights that nobody would dare to deny to any individual living in our modern times, the enjoyment of perfect health deserves definite priority on the basis of all that health encompasses in relation to man's happiness and productivity. Indeed, the concept of total health, as defined by the Organization Charter of the United Nations in the Preamble to the Constitution of World Health Organization, must remain comprehensive enough to include "a total and positive well-being, physical, mental and social, and not only the exclusion of disease."

This new definition of health has pushed back the old and traditional confines of our concern for the sick and infirm and has very importantly broadened our attitudes on and techniques of modern care. A positive and aggressive approach to health and its components has been developed to replace the old negative defence mechanisms. It is now well understood that the first and most successful attack against disease is the constant promotion and improvement of health. This positive health is not heaven's gift designed for the few and denied to many. It is rather the result and consequence of a deliberate and well-planned program of concrete and proven measures, undertaken and applied toward the health promotion of the individual from before his conception, right through his growth and development, and continued during his maturity and declining years.

To this program of positive and constant health promotion belongs also the complex and still developing chapter on disease and accident prevention. More and more specific and well-tried devices are now offered to help prevent the occurrence of situations that would alter, more or less seriously and per-

manently, this state of total well-being which characterizes health.

Through her influence over people on the occasion of her numerous contacts with various categories of the population, through her living example and demonstration of an individual actually enjoying physical, mental and social well-being, through her daily cooperation with the physician in this constant application of appropriate measures towards health promotion and disease prevention, the modern nurse has a very essential role to play among all the other health workers assigned to this great task of educating and guiding people on positive health.

Unfortunately and notwithstanding the progressive extension of the above concept and the greater and more intelligent applications of the measures mentioned, there will always be illnesses and accidents among us. The vital role of the nurse in the care of the sick and injured, and her functions, second only in importance to the physician's responsibilities on the treatment team are too well known, accepted and valued, to become the subject of a lengthy description. Indeed, the background, training and experience of our nurses have been traditionally geared to treating and helping the sick through their fight against disease and towards their recovery from the acute assaults of illness or injury. However, what has been lacking too long in this training and practice of the nurse has been her concern for the maximum functional recuperation of her patient, following acute episodes of impaired health. Too often, this *tender loving care* has remained misinterpreted in its conception and misplaced in its applications. We have even watched, in the past, such a strange situation as a *good* nurse, utilizing a very highly considered technique, impeding in fact her patient's fullest restoration to this comprehensive state of health described above, through her well-intentioned but inappropriate and prolonged protection and supplementation.

Fortunately, this very serious obstacle to the patient's return to total well-being is now very rapidly disappearing through the enlightenment of those responsible for the curricula in our schools of nursing, as well as through this progressive adaptation of nursing techniques to meet the comprehensive needs of the sick and injured, and to participate efficiently in the efforts undertaken by other health workers toward optimum functional results, even in the presence of anatomical impairments. We cannot refrain from applauding the birth and growth of what is now well accepted and developed as *rehabilitation nursing*.

In all her attitudes and at the occasion of every one of her ministrations for the good of her patient, the modern nurse must fulfil her obligations to the comprehensive program of care established on the basis of the team approach, being, among all the other health workers, the one who spends the greatest length of time with the patient. The nurse represents in the program a concentration and continuation of what has been undertaken by all the other disciplines.

At the time when our facilities have been expanded at the Rehabilitation Institute of Montreal to include inpatients' care, we have been very fortunate to secure a director of nursing and a nucleus of registered nurses, nursing assistants and nursing orderlies, who, altogether and most efficiently, have immediately demonstrated their willingness and ability to respond most satisfactorily to our expectations. Following a very short period of indoctrination and of in-service training, our nurses have competently taken their essential and unique place on our rehabilitation team.

The purpose of the following articles, written by our colleagues, is to situate this role of the nurse in the complexity of a comprehensive program. It is our hope that this undertaking will stimulate the formulation and development of comparable practices in other institutions where the sick are admitted and where the nursing personnel should be kept busy helping the patients through the fullest possible recuperation of all their functions and skills. It is undeniable that only through rehabilitation, suitably planned at the time of diagnosis and constantly pursued through all phases of treatment, can the total potential of the sick individual be completely

utilized in a modern scheme of total health care.

May I add here a word, in referring to the topic of administration, on the worthiness of the policy which guarantees the participation of the nursing staff, through the director of nursing, in all discussions and decisions on the various procedures considered and applied for the purpose of progressively improving the standards of modern health care. Concerning the specific field of rehabilitation, our recent experience at the Rehabilitation Institute of Montreal has been most convincing on the necessity and value of consulting with the director of nursing and the head nurses on all new and modified administrative policies and procedures. As it remains true with every other active member of the rehabilitation team, the objective observations and inner feelings of an intelligent and interested nurse may mean wonders in the way of right inspirations and correct gestures when the time comes for issuing new directives or altering already existing techniques. At our Institute we have found it most useful and practical to exploit the talents and abilities of fully trained nurses for such important administrative functions, in a rehabilitation setting, as the ones of admission officer, of coordinator of treatments, and of medical records librarian.

THE REHABILITATION NURSE

RUTH P. SMITH

A description of the manifold contributions the nurse makes to the rehabilitation program.

The role of the nurse on the rehabilitation team has not yet been definitely delineated but as one studies the process of rehabilitation one realizes that the *nurse belongs on that team.* It then becomes incumbent upon us to set down as specifically as we can her functions and responsibilities. However, before these can be defined, we must consider the philosophy of rehabilitation under which these functions can be carried out.

The ultimate aim of rehabilitation is to restore the handicapped individual to the fullest physical, mental, social, vocational and economic usefulness of which he is capable (not to nurse the disease but to nurse the whole person). In the words of Dr. Howard Rusk, "Rehabilitation extends from the bed to the job. Emphasis is placed on *ability* not *disability*. We teach people to live and work with what they have left."

Rehabilitation nursing comprises all the fundamental techniques of general bedside nursing care. In addition, certain specialized rehabilitation techniques must be practised. Among these are:

Methods of preventing deformities by proper positioning in bed and wheel chair, of preventing and caring for decubitus ulcers, of controlling incontinency through bladder and bowel training, application of braces and prostheses and, with the co-

operation of occupational and physiotherapists, the teaching of self-care activities and ambulatory techniques of brace and crutch walking.

The nurse needs to work harmoniously with all members of the rehabilitation team and must be aware of the role of the other members in order to *treat the patient as a whole*. This rehabilitation team consists of the physiatrist, responsible for planning and directing the rehabilitation program, the nurse, occupational therapist, physiotherapist, speech therapist, medical social worker, psychologist, psychiatrist, prosthetic specialist, placement officer and a school teacher for children and teen-agers.

Of all the team workers the nurse remains in immediate contact with the patient for longer periods of time. He may depend on her in a way that he may not depend on others, even the doctor. In point of fact, the nurses are and should be the eyes and ears for the other team members and can best interpret certain needs of the patient which others have not had the opportunity to observe.

An important part of the nurse's task is to alleviate the patients' fears and the depression that often results from crippling illnesses. She has to learn to recognize cultural and religious differences among the patients and the way these may affect their attitudes. She must be able to evaluate their intelligence and ability to follow instructions. The role of the nurse in the total program is woven so uniquely into the whole pattern of performance that the contributions of nurses in rehabilitation are manifold, namely:

ward manager, a practitioner of nursing skills and a teacher. She cooperates with the occupational therapist in teaching and supervising A.D.L. (activities of daily living), self-care and toilet activities, use of self-help devices and transfers from bed to wheel chair and from wheel chair to toilet. She assists the physiotherapist with gait training.

What qualities do we look for in the rehabilitation nurse? Of course she must have all the qualities of any good nurse, *plus*. She needs to be a warm, understanding person with a great deal of patience and tact. She must have teaching ability as she is required to instruct her staff, the patients and their relatives. Needless to say, emotional stability is paramount in maintaining good interpersonal and interprofessional relationships.

The basic principles of rehabilitation must be integrated into all areas of nursing, beginning with nursing arts. Many simple procedures such as washing the face and hands can have therapeutic value when the patient not only strengthens his muscles, but also improves his morale by beginning to assume responsibility for his own care and activities.

Helping the nurse in her rehabilitation work are the nursing assistant and the nursing orderly whose services are invaluable. The nursing assistant performs all nursing care except dispensing medications, injections and sterile techniques. The nursing assistant is therefore very valuable in relieving the nurse of routine chores and allowing her to concentrate her efforts on more specialized tasks. The nursing orderly, on the other hand, assists with the care of all male patients and has been trained to give all treatments that require sterile techniques such as, insertion and changing of indwelling catheters, bladder irrigations, care of rubber urinals.

Contrary to the practice in general hospitals all institute patients are *dressed* on the wards. In addition, all patients, unless otherwise prescribed by the doctor, take their meals in the cafeteria. Dressing completely when they get out of bed in the morning and eating in the cafeteria are part of the effort to reintegrate the patient in a normal milieu and make him as independent as possible.

Working among handicapped people, the nurse soon discovers that much of her stimulation for the work and her greatest inspiration can be traced to the courage of her patients.

All men think all men mortal but themselves. — EDWARD YOUNG

The Role of the Admitting Office

CAMILLE DE LA CHEVROTIÈRE

A patient's first contact with hospital occurs at the admitting office. Thus the role of the admitting officer is one of primary importance. It is upon her that the harmonious functioning of the institution depends.

Patients are referred to the Rehabilitation Institute of Montreal by general hospitals, physicians, charitable organizations, social workers, Workmen's Compensation Board, etc. Occasionally, they come on their own initiative. It is the responsibility of the admitting office to decide when patients should present themselves for preliminary examination and to notify them of the appointment by letter or by telephone. Meanwhile, it is necessary to compile a medical history from the information available. On the appointed day, the admission office registers the patient and directs him to the clinic where he is examined by a physiatrist. This screening procedure enables the physician to determine the advisability of initiating the rehabilitative process.

Services provided by the Institute include : a radiology department; a laboratory; departments of physiotherapy, occupational therapy, prosthetics and orthotics, speech therapy and audiology, psychology, psychiatry, and social work; a school and a placement service. Physicians refer patients to these departments according to their individual needs. When a patient requires a more extensive examination, the physiatrist calls on the services of a consultant. Radiologists, urologists and internists visit the Institute regularly. Appointments with these specialists are arranged by the admitting office.

If the patient's general condition is satisfactory, apart from his physical disability, he will, if ambulatory, become an out-patient. Treatments will be given two or three times weekly or even daily according to his needs. A coordinator, indispensable in a centre such as the Rehabilitation Institute, arranges the appointments so that the patient receives his treatments at a fixed time. This is done to avoid needless confusion. It is essential that the treatments be consecutive in order to avoid wasting the patient's time and, if he is an out-patient, prolonging his stay at the Institute.

Transportation for out-patients, particularly children, is provided as required by the admitting office. An ambulance brings the patient to the Institute and returns him to his home after the treatment.

When a patient is hospitalized at the Institute, it is the admitting officer's responsibility to make the necessary arrangements. To facilitate nursing care, patients having similar diagnoses and requiring similar treatment are grouped together, as far as possible, in the same department. The head nurse of the unit must be notified about the patient's arrival. At the same time, a copy of his rehabilitation schedule is sent to her so that she can help to en-

sure regular and punctual attendance at treatments. The admitting officer is thus the liaison between the patient, the departments, and the different units. It is in the admitting office also, that the method of payment is established.

In the field of research, the admitting office plays an important role. Research often necessitates the calling together of patients for the purpose of examination, observation and study. These appointments are made with the help of the admitting office.

Contacts between the admitting officer and nurses occur daily. Nurses are responsible for settling patients in their rooms. When a patient is to be discharged, the unit concerned advises the admitting officer. The nurse arranges for the patient's departure at the designated hour so that admission of new arrivals will not be delayed.

PHYSIOTHERAPY

J. HUTCHINSON, M.C.S.P., M.C.P.A.

A brief glimpse at the process of the re-education of affected muscles.

Rehabilitation begins immediately after the onset of a disability, be it physical or mental or both. Full rehabilitation can only be said to be completed when the patient has reached the point of maximum recovery. The rapidity and efficiency with which this end may be achieved can be accelerated by the combined efforts of the medical and auxiliary services. A lack of cohesion in these combined efforts or an inadequate interpretation of the goals necessary for assisting recovery can only be detrimental to the patient. The word *assist* cannot be over-emphasized for rehabilitation is not a passive procedure but the active encouragement by all members of the team towards making the patient realize his potentialities. These latter must of necessity be modified by the physical condition, mental outlook, home conditions and the age of the patient. In rehabilitation clinics the physician can correlate all services.

Physiotherapy is always emphasized as a physical measure but one cannot, for example, give electrical stimulation to a limb without taking into consideration the fact that the member is part of a complex human being, presently handicapped, parted from the family unit and more often than not, pinning his faith on those working towards his recovery.

Lord Horder stated in 1927 that "All physical methods of treatment are educational in character." All rehabilitation personnel act as instructors and this is particularly true in physiotherapy. But a therapist's teaching can only be really effective if it is combined with the qualities of patience, perseverance, tact and an optimistic outlook. Given these qualities and a sound knowledge of kinesiology, electrotherapy, hydrotherapy, massage and remedial exercises she is well equipped to treat the handicapped.

During the course of his treatment, the patient learns a little each day. Sometimes it may be the repetition of the previous instructions, sometimes a progression. The progression may be no more than a change in position so that a muscle may work harder, or an

increase in the number of times an exercise is repeated or the rate at which the exercise is performed. At times, the repetition of these instructions outside the hours of treatment can only be beneficial and this benefit can only be achieved by close cooperation between the nursing and physiotherapy services. The effectiveness of such teamwork may well be illustrated by considering three conditions: Amputations, paraplegias, hemiplegias.

Amputations

Here, the aim of the physiotherapist is to produce a conical stump, free from edema, with strong muscle power and no contractures. A stump may be subjected to intermittent pressure for an hour, resistance exercises for the muscles, stretching of any contractures and bandaging. Bandaging is necessary to produce a conical stump and must be continued 24 hours a day. Without the help of the nurse, the stretching of a flexion contracture may be rendered useless by the patient remaining seated for the rest of the day or the bandaging may become ineffective without the right amount of tension being maintained. When the patient has progressed to wearing his prosthesis in the ward, the nurses' observations are of great value.

Paraplegias

We all know the importance of bed positioning in the early stages of this condition. Good positioning can only be maintained over the 24-hour period by the nursing staff. Daily passive mobilization of useless joints through a full range of movement may be fortified by essential movements being repeated outside of treatment hours. The bladder training program demands close cooperation between the two services. The observations of fatigue and the patient's mental outlook are of great assistance when planning future treatments.

Hemiplegias

The hemiplegic patient may have heat for the relief of shoulder pain on the affected side, active movements of the affected joints and a passive range of movement where there is total paralysis. He may also benefit from balancing in the parallel bars, thus progressing to gait training between the bars and eventually walking independently. Our aim is to achieve a gait that is as nearly normal as possible, without mechanical aids. One hour spent on gait training in two periods during the day will be much more beneficial if the good habits we are teaching are emphasized when the patient is in the nurse's care. Clinging to the furniture can be discouraged if it is known that the patient is capable of walking the full length of a gymnasium or that the wearing of a temporary dropped-foot support eliminates a foot drag and renders the patient safe and consequently more independent.

It is the responsibility of both the nurse and the physiotherapist to ensure that they know and understand each other's work and in this way render their efforts more effective.

"My foot slipped off the brake pedal," was the only defence offered by a young woman whose car killed a young bystander. On her way to a luncheon, she was appropriately dressed right down to her smooth-soled, high-heeled shoes. Had she taken the 60-second-long precaution of changing to shoes with non-skid or ridged soles, 60 years of human life might have been spared.

Dress shoes on the seat beside the driver or in the glove compartment allow a quick change at destination. These few seconds could mean a lifetime for someone else.

— *Health Newsletter*, Saskatchewan Department of Public Health

* * *

Quarrels would not last so long if the fault were on only one side.

— De La Rochefoucauld

OCCUPATIONAL THERAPY

G. SKUHROVSKY, O.T.R.

Occupational therapy includes much more than teaching patients to knit or do leatherwork. It embraces all of the factors of normal living.

Occupational therapy is a rehabilitative procedure guided by a qualified occupational therapist who, under medical prescription, uses self-help, manual, creative, recreational and social, educational, prevocational and industrial activities to gain from the patient the desired physical function and/or mental response.

As suggested by the World Federation of Occupational Therapists, it may be prescribed by the patient's doctor for one or more of the following purposes:

1. To teach activities of daily living such as eating, dressing, writing, the use of adapted equipment and prosthesis.
2. To increase the range of joint motion, muscle strength and coordination.
3. To develop work tolerance and maintain special skills as required by the patient's occupation.
4. To help the disabled homemaker readjust to home routine with advice and instruction as to adaptations of special or modified household equipment and to the principles of work simplification.
5. As an adjunct to prevocational exploration, to determine the patient's physical capacities, interests, work habits, skills and potential employability.

For the purpose of this article we shall deal mainly with the aspects of occupational therapy involving the cooperation of the nursing services.

In the area of self-help activities the occupational therapist needs the nurses' understanding and cooperation. At the Institute the program is arranged to allow the therapists to treat the patients on the ward in the early part of the morning when they would normally be engaged in performing self-care activities, e.g., washing, dressing, feeding. There are two main reasons for this:

1. The retraining period is undertaken at the appropriate time and in the right setting.
2. The nursing staff is available to observe techniques used for individual patients and learn how to continue the patients' training by supervision or assistance until independence is reached.

The therapist is responsible for:

1. The simple techniques used to achieve this independence, e.g., one-handed method of tying shoe laces, correct method of transference from bed to chair, sequence of putting on clothing, etc.
2. Supplying or making any special equipment or devices to assist the patient, e.g. one-handed knife to cut meat, bath seat, sponges with various lengths and shapes of handles.
3. Demonstrating to the nursing staff the skills achieved by the patient.

The importance of this demonstration to the nurse cannot be stressed too much since:

1. The patient is involved with the problems of self-care during his entire waking hours.
2. The knowledge and understanding of the simple techniques involved in retraining ensure the continuity of supervision and instruction during the absence of the therapist. This is especially important with hemiplegic patients who occasionally forget the methods taught or the correct sequence of an activity, e.g. eating meat before dessert if the food is incorrectly placed on the tray.
3. By becoming independent through self-care the patient requires less nursing care.

4. The nurse often acts as liaison between the therapist and the family. Through interpretation of the patient's capabilities and demonstration of the techniques used, the family may be encouraged to continue the program at home and allow the patient to maintain the level of independence achieved at the Institute.

Independence is said to be achieved when *all* steps required for the completion of one activity can be accomplished without help as, for example: *Brush teeth:* the patient is able to manoeuver to the bathroom, turn on the faucet, take the glass, tooth paste and brush, brush the teeth and return all items to their proper place.

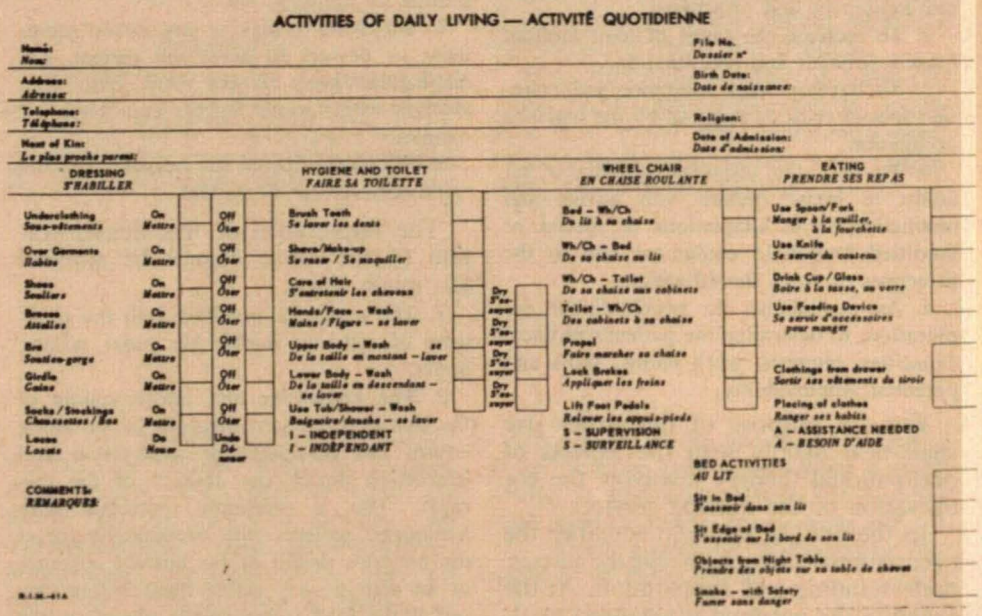
The ability to carry out the entire performance is recorded on the special A.D.L. card under: *Brush teeth.* (See below). The reasons for using this record are:

1. Spot check for the nurse as to what phase of retraining the patient has reached.

2. Special areas where the patient needs supervision. This is especially necessary during transference to and from the bed, toilet and bath as patients are sometimes fearful of trusting their own ability to perform these activities alone. It is of particular importance with the hemiplegic patients who do not always remember to balance correctly or extend the knee on which they are standing to ensure stability in transference. Whenever the therapist feels that a patient is forgetful this is the area most likely to require continued supervision on the part of the nurse.

Writing retraining is undertaken by the occupational therapist who deals with the *mechanics of writing,* e.g., holding pencil or pen, with or without adaptors, stabilization of the paper and the basic forms used for letters. On the other hand, the speech therapist deals with the *content.* When the patient has achieved sufficient skill with the forms — the words used to practise are obtained from the speech therapist and *only* those words are used.

Practice in the basic forms used in writing retraining could be continued on the ward, as it is only by repetition that the patient can hope to achieve control over the size and shape of the letters. Many patients, and especially children, do not have the self-discipline or initiative to work on their own. Because of this, the encouragement given by the nurse to the pa-


ACTIVITIES OF DAILY LIVING — ACTIVITÉ QUOTIDIENNE

Name: / Nom:

File No. / Dossier n°

Address: / Adresse:

Birth Date: / Date de naissance:

Telephone: / Téléphone:

Religion:

Next of Kin: / Le plus proche parent:

Date of Admission: / Date d'admission:

DRESSING / S'HABILLER

Underclothing / Sous-vêtements — On / Mettre — Off / Ôter

Over Garments / Habits — On / Mettre — Off / Ôter

Shoes / Souliers — On / Mettre — Off / Ôter

Braces / Attelles — On / Mettre — Off / Ôter

Bra / Soutien-gorge — On / Mettre — Off / Ôter

Girdle / Gaine — On / Mettre — Off / Ôter

Socks / Stockings / Chaussettes / Bas — On / Mettre — Off / Ôter

Gown / Jaquette — On / Mettre — Undo / Défaire

HYGIENE AND TOILET / FAIRE SA TOILETTE

Brush Teeth / Se laver les dents

Shave/Make-up / Se raser / Se maquiller

Care of Hair / S'occuper des cheveux

Hands/Face — Wash / Mains / Figure — se laver

Upper Body — Wash se / De la taille en montant — laver

Lower Body — Wash / De la taille en descendant — se laver

Use Tub/Shower — Wash / Baignoire/douche — se laver

I — INDEPENDENT / I — INDÉPENDANT

Dry Self / Se sécher

WHEEL CHAIR / EN CHAISE ROULANTE

Bed — Wh/Ch / Du lit à sa chaise

Wh/Ch — Bed / De sa chaise au lit

Wh/Ch — Toilet / De sa chaise aux cabinets

Toilet — Wh/Ch / Des cabinets à sa chaise

Propel / Faire marcher sa chaise

Lock Brakes / Appliquer les freins

Lift Foot Pedals / Relever les appuis-pieds

S — SUPERVISION / S — SURVEILLANCE

EATING / PRENDRE SES REPAS

Use Spoon/Fork / Manger à la cuiller, à la fourchette

Use Knife / Se servir du couteau

Drink Cup/Glass / Boire à la tasse, au verre

Use Feeding Device / Se servir d'accessoires pour manger

Clothings from drawer / Sortir ses vêtements du tiroir

Placing of clothes / Ranger ses habits

A — ASSISTANCE NEEDED / A — BESOIN D'AIDE

BED ACTIVITIES / AU LIT

Sit in Bed / S'asseoir dans son lit

Sit Edge of Bed / S'asseoir sur le bord de son lit

Objects from Night Table / Prendre des objets sur sa table de chevet

Smoke — with Safety / Fumer sans danger

COMMENTS: / REMARQUES:

A simple A.D.L. (Activities of Daily Living) check card is kept by each patient's bed and filled in by the therapist. This record indicates in which areas the patient is independent, needs assistance or supervision.

tient decreases the time needed to achieve a legible handwriting.

Prosthetic training of the upper-extremity amputees requires:

1. Training in the use of the prosthesis;

2. building up wearing tolerance of the prosthesis;

3. maintaining a high standard of cleanliness regarding their person and the prosthesis.

Training in the use of a prosthesis and building up wearing tolerance are done simultaneously. The therapist instructs the patient in the basic motions of operation and pre-positioning the various terminal devices. After the patient has achieved sufficient skill in the use of the prosthesis and the work tolerance has increased to one hour, the aims of treatment are geared towards the patient's vocational future.

Building up wearing tolerance of the prosthesis and cleanliness are two areas in which the nurse and the therapist must work in cooperation. The patient is required to wear the prosthesis, in addition to the treatment, for specific periods of time during the day to build up tolerance and allow him to:

1. Condition the skin to friction and pressure of the straps and harness;

2. accustom the patient to the weight of the prosthesis.

The patient is taught by the therapist how to care for the prosthesis but he does not always carry through with this part. Consequently, additional supervision is needed by the nurses because:

1. At the Institute, the stump socket is usually made of plastic and is non-porous;

2. there is a plastic band over the axilla loop which becomes easily soiled and deteriorates if perspiration accumulates;

3. stump socks should be washed *daily*, sometimes changed twice daily, if the patient perspires profusely.

The areas which come in contact with the patient's skin should receive daily care. The stump socket and axilla loop should be washed and dried with a sponge, but under no circumstances must the prosthesis be immersed in water. The patient is usually not sufficiently knowledgeable to be able to evaluate the various materials used in the prosthesis, e.g., steel, leather and wood. These deteriorate if continuously put into water.

In understanding the treatment sequence and the importance of building up the wearing tolerance of the prosthesis the nurse can give the therapist invaluable assistance by making sure that the patient wears the prosthesis at the prescribed times and that demands are not made on him to perform activities for which he is not ready. This is especially important with patients who have difficulty in accepting their prosthesis and children whose frustration tolerance is low.

ASSISTANT TO DIRECTOR OF SPECIAL PROJECT

An interesting assignment for a registered nurse is available in the Canadian Nurses' Association office assisting the Director of the project for the Evaluation of the Quality of Nursing Service. The candidate should be free to travel, able to meet and deal with people and situations on an objective basis, conduct interviews, and carry out other duties related to a professional study.

Please address enquiries to:

CANADIAN NURSES' ASSOCIATION,
74 Stanley Avenue, Ottawa 2, Canada.

Prosthetic and Orthotic Appliances

C. CORRIVEAU, C.P.O.

The work of this department is three-fold: to fit the individual with a prosthesis or orthotic appliance that is esthetic as well as functional; to provide a supervised training program for the patient so that he becomes familiar with the use and care of his apparatus; to provide instruction for students interested in this field.

In 1957, due to the generosity of various organizations, the Rehabilitation Institute of Montreal added a department of Prosthetic and Orthotic Appliances to its numerous services.

Prosthetic devices are not products of the modern era. Excavations at Capua, Italy, unearthed a metal leg that had been in existence nearly 2,000 years. In 484 B.C., a Roman prisoner who was chained by the leg, amputated it in order to escape and later made himself a wooden prosthesis. In 200 B.C., the Roman general Marcus Sergius lost a hand in combat. An iron hand was made to replace the lost one. It is said that he returned to war following his recovery and with amazing skill was able to create havoc among his enemies.

Before explaining the work of the prosthetic and orthotic appliances section of the Institute, a definition of the following terms is essential:

Prosthesis: Apparatus that has as its objective the *replacement*, in all or in part, of an organ or an amputated limb.

Orthotic Appliance: Apparatus devised and used to *prevent* atrophy; to give support and correction to a limb or a part of the body affected by paralysis or faulty musculoskeletal development.

Accredited in 1959 by the American Board for Certification, the Prosthetic and Orthotic Appliance section of the Institute is presently providing instruction to three students who hope to become specialists in this field. Some of its graduates have already developed similar workshops in different hospitals in the province as well as in foreign countries. Of the seven students who have graduated from this course four are now members of the staff. Personnel in this department consist of:

2 specialists in the field of prosthetic and orthotic appliances,
4 orthotic appliance specialists,
1 director of leather work,
1 store-keeper (stock),
1 secretary,
3 students (1 studying prosthesis, 2 studying orthotic appliances).

This staff is scarcely sufficient to meet the ever-increasing demand. The tables following illustrate the growth of the department since its inception.

Today, adjustment of prosthesis has become regular practice. Even a carefully adjusted prosthesis, however, will only be useful if the stump has been well-prepared by both surgery and physiotherapy. The modern surgeon is better informed than his predecessors about orthotic appliances and their possibilities; he is free from the antiquated belief that a stump is useful in proportion to its length. The trend is

Table I

OUTPUT

From April 1,	1957	1958	1959	1960	1961
Orthoses	68	184	306	389	198
Prostheses	0	6	14	47	90
Special Appliances	10	12	23	46	57

Table II

REPAIRS — ADJUSTMENTS

From April 1,	1957	1958	1959	1960	1961
Orthoses	163	307	391	770	378
Prostheses	6	5	20	53	64
Special Appliances	0	2	5	4	12
New Pairs of Shoes	66	149	176	281½	219
Alteration of Shoes	123	291	382	592	271

to amputate at a higher level in order to facilitate the use of a prosthesis that will be functional as well as esthetic.

Aside from psychological considerations, the amputee's acceptance of his prosthesis will be determined by such things as: its appearance; its weight; its resistance to wear and tear; its easily cared for construction. All of these qualities can be found in the recently developed plastic prostheses. They are better fitted to meet the demands of modern living — from the cosmetic as well as the functional point of view. Plastic, blended with woven silk, jersey, nylon and glass fibre, results in a very light product. It is gradually replacing the conventional elements of wood, metal and leather.

No apparatus is made at the Institute without prior consultation and prescription from the attending physiatrist. The apparatus (prosthetic or orthotic) is devised and prepared by the specialists concerned according to the needs of the patient. It passes through several stages before completion.

The patient's stump is measured carefully. The socket of the prosthesis is hollowed or moulded to fit these measurements exactly. An adjustable jig is used to train the patients with amputation of lower limbs. This eliminates some initial difficulties in that an adjustable apparatus allows for lengthening or shortening of the prosthesis; it permits the wearer to shift the stump's point of support; to change the angle of the foot, etc. The objective is to reproduce, as closely as possible, the patient's usual preoperative gait.

The final prosthesis will be completed when all the measurements and alterations that have been obtained from the use of the adjustable jig are satisfactory and the patient is entirely at ease and comfortable. This procedure diminishes the number of adjustments, permits the physician to make suggestions at the appropriate time, and assures a better adjusted prosthesis.

Precise measurements are equally essential for an orthotic appliance. A fitting is required at a certain stage during construction, so that the eventual efficiency of the apparatus can be determined. It must be emphasized that each patient who has received a prosthesis or an orthotic appliance from the Institute, undergoes a supervised training program and becomes well acquainted with the apparatus, its care and maintenance before being discharged.

The nurse's role is important at this point. When an appliance is given to a hospitalized patient at the Institute, she is asked to collaborate with the physiatrist and the prosthetic and orthotic appliance specialists. She must know that the patient is wearing his apparatus as ordered so as to increase

his tolerance. Being in almost constant contact with the patient, the nurse is in a better position than anyone else to note his reaction to the new apparatus; to appreciate his adjustment and the new independence acquired through the use of this appliance. The nurse's moral support, encouragement and enthusiasm help to restore her patient's confidence — confidence diminished by the amputation of a limb or the loss of its function.

In Memoriam

Elizabeth H. (Jackson) Alton, (Toronto East General Hospital '37) died late last year.

* * *

Margaret (Bishop) Bishop, (Kingston General Hospital '38) died on January 4, 1963 after a long illness. Mrs. Bishop had engaged in private nursing for the greater part of her career.

* * *

Matilda Blewett (Edmonton General Hospital '13) died late in November 1962 in Arizona. She had served in the Canadian Army Medical Corps in Canada, England and Greece during World War I. Most of her professional life was spent in the United States.

* * *

Kathyleen V. Boutilier (Victoria Public Hospital, Fredericton '50) died recently in Fort Lawrence, N.S. A former supervisor in Moncton City Hospital, she later became superintendent of nurses, Highland View Hospital, Amherst, N.S. In 1960 she resigned from this position.

* * *

Stanley Thomas Bradshaw (Mapperley Hospital, Nottingham, Eng. '53 and City Hospital, Nottingham '56) died in Fort William, Ont. late in November, 1962.

* * *

Anne Brassor (St. Vincent de Paul Hospital, Brockville '11) died in Brockville recently. She was a member of the first secular graduating class of her hospital's school of nursing. Her professional career was spent in private nursing.

* * *

The alumnae association of the Vancouver General Hospital pays tribute to the memory of the following graduates: **Kathleen Mollie (Bunbury) Briggs '17, Ethel Irene (Smith) Brouse '21, Margaret (MacLean) Forse '22, Ida Frances (Lougheed) Lougheed '18** and **Bertha M. Youdall '14.**

* * *

Elsie (Charles) Brough (Medicine Hat General Hospital '15) died on November 20, 1962 in Vancouver. She had served as a nursing sister during World War I.

* * *

Blanche Campbell (Nicholls School of Nursing, Peterborough, Ont. '22) died during 1962 in Chicago, Ill.

* * *

The alumnae association of St. Paul's Hospital, Vancouver pays tribute to the memory of: **Mary Elizabeth Carney '24** and **Katherine M. (Doumont) Galloway '23.**

* * *

Florence I. Chiu (Wang) Chang (Isabella Fisher Hospital, Tienstsin, China '31), an Ontario nurse, died in Cleveland Heights, Ohio in 1962.

* * *

Flora Dorothy Cox (Winnipeg General Hospital '28) died in Toronto on November 21, 1962. Miss Cox was on the staff of Toronto General Hospital.

* * *

Annie Louise (Bowie) Cranston (Collingwood General and Marine Hospital, Ont. '04) died on November 8, 1962.

* * *

Helen (Gilroy) Dickson (Kingston General Hospital '21) died in Detroit, Mich. early in 1962.

* * *

M. J. I. Denise Donaldson (Notre Dame Hospital, Montreal) died as the result of an accident late in 1962. She was in her twenty-eighth year.

(Continued on page 256)

SPEECH THERAPY

LOUISE CODERRE, M.A.

Whatever may be his education, his work, his aim in life, man possesses an instinctive need to communicate.

Communication is achieved in a variety of ways through essentially symbolic means that include gestures, facial expressions, music and painting. However, in versatility, intricacy and ingenuity, language far surpasses all other means. Man uses it to express his physical and emotional needs; to give substance to his thoughts. It is indispensable to satisfactory adjustment to his surroundings. The individual who has been deprived of speech, for any reason, should have access to treatment conducive to recovery. It is for this purpose that the Rehabilitation Institute of Montreal provides its patients with the services of a department specializing in speech therapy and the relation of hearing to speech.

Speech therapy is concerned with evaluation of speech disturbances, either in the use of language or in the use of the voice, and in the techniques of retraining. Disorders of this type may be encountered in cases of paralysis originating either in the central or peripheral nervous systems; in laryngeal conditions; in congenital anomalies of the organs of speech such as harelip and cleft palate. Problems related to stammering; functional difficulties in articulation; delay in the proper use of language as demonstrated by inadequacy of vocabulary and poor grammatical construction; reading difficulties in children handicapped by specific visual or hearing deficiencies also come within the scope of this specialty.

A special phase of speech therapy is related in particular to deficiencies in hearing. Clinical examination and audiometry help to determine the extent of deafness. If the hearing loss is beyond hope of recovery, the patient can be taught to lip read. On the other hand, if any worthwhile residue of hearing remains, the patient can be fitted with the hearing aid best suited for him.

Speech therapy may be considered under three different aspects: Re-education in the use of language; muscle training; phonetics. Rehabilitation in one or more of these fields may be necessary depending upon the specific problem.

Re-educating the patient in the use of language involves improvement in his understanding of both the spoken and the written word and in his ability to express himself through his vocabulary, through sentences and finally through spontaneous conversation. This requires both auditory and visual stimulation. The aim of muscle retraining is to restore the function of the lips, tongue, soft palate and organs of respiration to the extent necessary to produce an even tone and normal rhythm. Finally, phonetic training assists the patient to articulate properly.

Before discussing the relationship and the necessity for cooperation between speech therapist and nurse, the work of the former should be defined. Since this is the main core of this presentation and since we are concerned with speech therapy and nursing within the confines of a rehabilitation institute, one category of patients that will be of most interest to both professions is emphasized. This is the aphasic

hemiplegic group as well as children affected with cerebral palsy and aphasia.

The Role of the Speech Therapist

It is the responsibility and the duty of this person, as working conditions permit, to explain the patient's condition to the nurse and, as far as possible, to indicate the best way to handle him. As further questions arise, the nurse should feel assured of the therapist's willingness to answer them in the interests of the patient's welfare. Some nurses have requested permission to attend speech therapy sessions. Unfortunately, past experience has shown that the presence of a third person hinders the patient; disturbs his ability to concentrate; robs him of the full benefit of his treatment period. Consequently, it is preferable to have the nurse receive her explanation at another time.

In discussing what the therapist should tell the nurse, let us relate it specifically to the care of the aphasic patient. Aphasia is a highly complex problem. It may be described as impaired ability to use the symbols of communication. The aphasic patient experiences difficulty in the use of words, either spoken or written, as well as gestures. The level and degree of impairment varies. Some patients lose the muscle coordination necessary to articulation of words. This lack of coordination may extend to the muscles of the limbs so that the person is unable to carry out such movements as those required for washing, dressing and eating. This condition is called *apraxia*. Other patients find that they are incapable of expressing their thoughts, while a third category exhibits inability to comprehend what is said although there is no demonstrable loss of hearing. In addition, if reading and writing are considered as the use of symbols, then the aphasic patient experiences further loss through his inability to use these means of expression in a normal way. From this there emerges a principle that the nurse must remember and observe: Although he experiences difficulty in abstract thought, the aphasic individual is an intelligent human being and must be treated as such.

The Nurse's Role

1. *In relation to the therapist:* The nurse is able to provide valuable information concerning the patient's behavior and his use of language. Frequently the patient who has been unable to recall certain words during treatment is successful in doing so in the seclusion of his own room.

2. *In relation to the patient:* The aphasic adult tires very quickly, physically and emotionally. He has trouble controlling his emotions and his inability to express himself makes him cling to a routine as a means of security. Consequently, the slightest variation in his accustomed activities can result in anxiety severe enough to offset the effects of treatment. The nurse must see to it that the aphasic patient is forewarned of and prepared for impending change; that he appears regularly for treatment; that he has an opportunity to rest after treatment since the degree of concentration required is frequently exhausting.

Now, what should be the nurse's attitude in the case of specific difficulties in articulation or actual speech? It is hard to lay down general rules. With some patients, for example those who have difficulty in coordination or in following through the various steps of an act, it is preferable to avoid speaking to them when they are engaged in activities such as dressing or eating. On the other hand, in the case of the majority of aphasic patients, it is recommended that the nurse should speak to them. In addition to giving them confidence, it forces them to establish social contact — something that they may tend to avoid.

In chatting with the aphasic patient, the nurse should confine herself to short, simple sentences related to objects in his environment since this is the context that he can grasp most readily. Otherwise, communication will not take place and the patient's frustration will be increased. Avoid making comments in his presence, since there are frequently intermittent flashes of understanding. Attempts to establish communication between the nurse and the patient should be characterized by ease and lack of strain. For example, as the aphasic goes about his tasks of washing and dressing, the names of

articles can be indicated although we believe that this should be done in a casual manner. To be more specific, the patient should not be urged to repeat the names of articles since, as has been indicated previously, some persons are unable to do so and efforts in this respect may be harmful. However, the very fact of hearing words spoken, of associating them with the objects that they represent is a valuable contribution towards the patient's recovery.

Finally, the nurse can encourage social contacts between aphasic patients; introducing them to each other, promoting gatherings that tend to stimulate speech.

In her relationship with the child who has speech difficulty, the nurse adopts a similar attitude to that used with adults. She gives some indication of his behavior; prevents him from becoming over-excited prior to speech training periods; encourages communication by praising him for successes; arranges to have him meet with others of his own age. The cerebral palsy child frequently requires special attention at meal-time. On the advice of the therapist, the nurse may arrange to have him served food that will improve the function of muscles involved in chewing and swallowing since these muscles are also used in speech.

Conclusion

Rehabilitation of the patient with speech difficulty requires painstaking effort. Progress is often scarcely noticeable. The patient is easily discouraged. However, the nurse can assist in developing an environment that allows the therapist to use her resources to the full in guiding the patient toward his goal of verbal communication.

Santos Works Again

Santos was a normal, healthy boy of 14 who lived in La Paz, Bolivia. That was eight years ago, and he was working as a helper at an oil field. One day he climbed a pole to watch for the approach of a truck on which he was to work. In sport, a companion shook the pole, causing Santos to lose his balance. In trying to break his fall he grasped a high tension wire and was severely burned. His injuries necessitated the amputation of both arms.

Nine months after the accident, Dr. Gustave Gingras, Executive Director of the Rehabilitation Institute of Montreal, was on a mission to South America and was asked to evaluate the rehabilitation possibilities for Santos. As a result of this evaluation, the Institute arranged for the boy to come to Montreal where he was to be fitted with artificial limbs and taught how to use them — all gratis. Eight months later he returned to his home in Bolivia.

For six years Santos lived and worked hard with his artificial arms, but then catastrophe struck again — his beautiful artificial arms had worn out! He had saved enough to buy a one-way ticket to Montreal, but how could he live there, buy his new arms, learn how to use them and get back home again? He sent an S.O.S. to Dr. Gingras who immediately interested himself in the plight of young Santos, now 22. He enlisted the aid of the government of Bolivia, Easter Seals, the Canadian March of Dimes and the Canadian Red Cross Society, and Santos came again to Montreal for rehabilitation.

At the time of his return to La Paz he wrote Red Cross headquarters: "Six years ago, through the generosity of many people, I was able to come to Canada and be fitted with artificial arms. Due to constant wear, those arms are now worn out and new ones have become a necessary expense. I am now back in Montreal where the Rehabilitation Institute is providing me with new appliances and training me in their use. All this is possible because of you, the Canadian Red Cross, who have so generously contributed the cost of my new arms. I thank you from the bottom of my heart."

— *News of Red Cross*, Sept., 1962

The Role of the Psychologist

J. M. CHEVRIER, LIC. SC. PED., PH.D.

Through his ability to estimate patients' capabilities, the psychologist assists in five different areas.

Role in Diagnosis

Psychological techniques are used to complete rehabilitation diagnoses by providing information on the mental and emotional components of the handicapped patients, on their social behavior and on the degree of their ability to follow instructions in rehabilitation.

INTELLECTUAL ASPECTS

Psychological techniques provide the following services :

1. *Assessment of mental level* and intellectual maturity prior to a trauma, amount of deterioration, present mental resources and efficiency, willingness to follow instructions, comprehension of orders and attentiveness in the treatments given in the various treatment sections: physiotherapy, occupational therapy and speech therapy.

2. *Assessment of intellectual background* in relation to the advisability of attending school; whether the patient should resume studies at the same level as when interrupted by accident or sickness or be promoted to a higher level; whether he should be directed toward college education, apprenticeship or job.

3. *Assessment of application and learning pattern* in relation to concentration power and maturity in order to determine ability to master the techniques of talking, walking, reading and calculating.

4. *Evaluation of interests, attention level,* and *dexterity* through manipulation of blocks, puzzles, paint brushes and participation in games to obtain relaxation.

PERSONALITY ASPECTS

Although it is important to evaluate the patient's mental capacity and intellectual maturity, the psychologist must also :

1. Study the patient's *innermost self.*

2. Observe his *behavior reactions* to fellow patients, his normal or pathological identifications, and, in order to ensure efficiency of treatment, his relationship with his parents and family circle, his wider social environment, his stability and emotional security, his inner resources, etc.

As the diagnostic element cannot be neglected at any time, it is also essential to consider the patient's body image, his interior and exterior kinesthetic experiences, which make him aware of himself as an active entity. It becomes also of paramount importance to analyze his ability to work, accomplish things, walk, run, talk, laugh, cry, express hostility, love, hate, even his power of destruction.

This perception of the self in daily living, in private or public life, most of the development of which is said to take place from the age of six and over, is an important factor in efficacious treatment. It is the psychologist who can evaluate, appreciate and interpret its multi-variations to help patients to understand themselves, in order that they may learn to deal with their problems and make effective use of their abilities. In this connection, it is important that the psychologist dis-

cuss the patient's needs and abilities, with the nursing staff.

Role in Prognosis

Moreover, psychological evaluations help to clarify the prognosis regarding the psychological evolution of the sick person, on his educational potentialities, training possibilities and the advisability of finding a job for him. It also helps in determining his intimate and social behavior, so that the physically handicapped may make slow and gradual progress towards greater independence and freedom.

However, in some patients, "as soon as total incapacity is extenuated and as the first anxiety tends to diminish, a precise type of disability creates a precise type of personality."*

Because of techniques at his disposal, his ability to interpret psychometric findings obtained through interviews, and his knowledge of the educational and vocational world, the psychologist is in a position to prognosticate quite accurately the degree of rehabilitation expected from a patient in those areas.

Finally, observations during interviews and the findings of projective tests also provide valuable results in:

1. Prognosis of the patient's behavior in family situations or in a medical set-up.

2. The patient's adaptation and ability to reach a satisfactory identification with persons of both sexes, with relatives, friends and neighbors, and during the course of hospitalization, with members of the team, particularly doctors and nurses.

Role in Treatment

The collaboration of the psychologist, at treatment level with the other sections of a rehabilitation centre, is defined by and adapted to the needs of the patients and the requirements of the various services.

In *occupational therapy*, one of the main concerns is the occupational possibilities of the patient. Moreover, the patient's condition, for instance a right hemiplegia, may indicate the need for re-training in left-hand writing, in which case it is necessary to assess handedness previous to left-hand training. In this respect, the child, having acquired a greater independence, may become a candidate for kindergarten or primary school.

In *speech therapy*, the psychologist acts as a collaborator by evaluating the reading rhythm of non-aphasic patients, through the medium of a rating machine, which checks the speed of oral or silent reading and assesses progress. Furthermore, the evaluation of the patient's mental age and psychological maturity helps to determine the rhythm of spech habilitation and/or rehabilitation. These findings are given due consideration by the speech therapists in their treatment.

In *nursing*, the psychologist must establish contacts with the nurses in order to study the hospitalized patient's behavior, his reactions to treatment, to other patients and to doctors. The patient's identifications to persons of the other sex, his aggressivity or dependence and presence or absence of parents during visiting hours are all important and interesting factors.

Role in Education and Vocational Guidance

When the patient has reached an educational crossroad or when the parents seek counselling, the psychologist may, after interviews and evaluations, guide the individual concerned towards kindergarten, primary school, college, convent, high school, trade school or apprenticeship, evening or correspondence courses. If immediate work or apprenticeship is the only solution, the psychologist assists with the preliminary arrangements.

With adult patients, the psychologist is required to collaborate in four major areas:

Straightforward guidance for those patients, who, without handicap, would never have had the opportunity of being objectively evaluated.

Vocational re-evaluation of patients who have to undergo retraining and seek for a completely new field of endeavor.

Re-adaptation to their former occupation of patients who must achieve progressively their former level of efficiency.

Re-integration within their home of women who must be helped to face the demands of their daily tasks as well as to

* Wilson, Arthur Jess, "The Emotional Life of the Ill and Injured," *Social Sciences*, New York, 1950, p. 31.

shoulder the responsibilities of womanhood.

Rehabilitation-minded nurses should understand and study these various problems and be in a position to help the psychologist in his evaluation, when necessary.

Role in Specialized Education

Notwithstanding this approach to the problem of fundamental and primary education for the physically handicapped, consideration should be given to investigation of other provisions for children who positively cannot attend regular schools. Encouraging achievements have already resulted from special teaching and special schools for the handicapped. Another equally important field of cooperation exists between experts in education, psychology, the medical and paramedical professions.

The Nurse and the Psychiatrist in Rehabilitation

P. MOREAULT, M.D.

In her daily contacts with the physically handicapped, the nurse must give special attention to mental and emotional needs.

Any approach to the sick requires consideration of mental and emotional needs. In the case of the physically handicapped, these psychic factors assume a much greater importance. They are of major concern in the provision of effective care. The role of a nurse working in a rehabilitation centre could best be defined if placed half-way between two poles: one would be represented by psychiatric nursing, such as that practised in a mental hospital; the other would correspond to nursing as practised in a general hospital. Therefore, special knowledge and skills are required by the nurse who wishes to devote her efforts to the needs of the physically handicapped. The role that she plays as a member of the rehabilitative team is of prime importance.

Any attempt to define, in psychiatric terms, the role of the nurse who cares for disabled persons, will meet with difficulty; her functions are too numerous and varied to be incorporated in a definition which by its very nature would be too arbitrary. Such a definition would, in effect, prevent an understanding of the complexity and multiple aspects of this role. We believe that it will be more desirable to describe, in succession, the various responsibilities which the nurse must meet when caring for handicapped persons — persons who are susceptible to emotional conflicts that may be overt or perhaps covert. No distinction will be made between the patient who reveals emotional conflict either in relation to his disability, or otherwise, and the one who appears to be emotionally untroubled by his handicap. Indeed, such a distinction would be inconsistent with the clinical data; it would

ignore the therapeutic aspect of the relationship that is established between the nurse and each patient.

Moreover, parents presenting emotional problems have similar needs to those who appear undisturbed. The nurse must carry out certain functions for all handicapped persons — not only for those who suffer from emotional troubles. Only special factors relating to this last category of illness will be discussed.

Nurse Responsibilities

a. *Detailed observation of reactions and behavior:*

It is an established fact that every handicapped person is affected emotionally by his physical disability.

Thus, one of the first essential functions of the nurse will be to observe the attitudes, reactions and behavior of each patient. These observations will give her definite indication of his emotional state. In the case of patients suffering from emotional problems and who have had psychiatric evaluation, the nurse's observations will be very useful to the attending psychiatrist. They will enable him to follow any developments in the patient's mental state and will give him a better understanding of the factors involved in the conflict. The nurse's comments about patients who have not yet undergone such evaluation will help the physiatrist to determine whether or not the patient requires a psychiatric examination.

b. *Importance of daily charting.*

We believe that this aspect of the nurse's role requires emphasis. It appears to develop logically from the foregoing responsibility. In our experience, there is a tendency for nurses to neglect to chart fully enough the observations and findings made during the course of the day's contact with their patients. These remarks, even though they might appear commonplace or without importance to an outside observor, are often very useful to the attending physician; they are even more valuable to the psychiatrist. After all, it is the nurse who, in the majority of cases, spends the greatest number of hours with the patient; she is able to obtain much knowledge and often deep insight into her patients. A simple yet revealing example will illustrate why we consider charting so important and why we stress it in our work.

A patient, who became hemiplegic as a result of a cerebral vascular accident, had a depressive reaction. He frequently tried to disguise his depressive feelings. Close observation of his behavior, his relationships with other patients and with nursing personnel, his manner of eating and sleeping, allowed the doctor to determine the depth of his depression and to follow his progress from day to day. These observations, made by a nurse, would have been useless, however, if she had not recorded them carefully as part of the medical history.

c. *Close supervision of certain patients:*

Supervision is an integral part of the nurse's role. It naturally assumes greater importance in psychiatric hospitals where there is a larger number of patients requiring close supervision than in a rehabilitation centre where fewer patients present major psychiatric symptoms. Close supervision should be provided, however, for disabled persons who show signs of depression — whatever the *apparent* severity of the condition. All depressed patients must be considered as potential suicides. No one can predict at what moment such a patient may attempt to do away with himself.

Another group of patients requiring equally close supervision consists of those who are mentally confused. These individuals often wander from one place to another, risking injury or creating confusion and disorder wherever they are. All patients who give evidence of chronic cerebral syndromes lack frustration tolerance; they sometimes display quite pronounced aggressive reactions. The nurse must prevent such manifestations of hostility from being provoked by or directed against other patients. She should, with the help of other nursing personnel, attempt to reduce these aggressive, uncontrolled reactions to the minimum in order to obtain the patient's cooperation.

d. *As a therapeutic agent*

Administration of medications, as well as observation of their effects on the patient, are important functions of the nurse. However, there is another function which we consider to be of greater importance due to its reper-

cussions on the well-being of the patient. We refer to this function as "maternal substitute." This term indicates the fundamental role that the nurse assumes when near her patients. In this capacity her activities are many: her maternal role is an integral part of the daily care that is provided for the sick. It can be observed when the nurse is bathing or feeding a patient; when she is clothing, protecting, disciplining, persuading, reassuring or consoling him. The nurse protects her patient from the consequences of his own weakness and helplessness as a mother protects her child. This role demands her complete acceptance of the individual. As the mother loves her child because he belongs to her, so the nurse should accept the patient as a human being with inherent dignity and worth — not because the dependent relationship satisfies some of her own emotional needs. The principles of protection, tenderness, and complete acceptance are entirely applicable to the nurse-patient relationship. They are based on the nurse's interest in helping the individual and in developing his potentialities.

The nurse's attitude, as well as the manner in which she carries out all of these activities will have a beneficial or harmful influence on his recovery. The disabled person at a certain period of his illness requires help in carrying out daily activities. Over-protection by the nurse, however, will only encourage him to be overly dependent and passive. This tendency toward passivity is common in handicapped patients; they also tend to indulge in a state of dependency. One of the most important factors in achieving and developing a satisfactory rehabilitation program for the handicapped person will be his own ability to master his inclination towards passivity. The nurse must avoid encouraging such a state; she must help the patient to direct his strength and energy toward the recovery of the musculoskeletal functions of his body.

Another aspect of the nurse's role as a therapeutic agent should be mentioned when considering her attitude to the emotional reactions and behavior of each patient. She can and should be a psychotherapeutic agent whose influence, although often unrecognized because of its subtle and unobtrusive nature, is frequently a decisive factor in the patient's progress. The danger of over-protecting a patient who has obvious tendencies towards dependency and passivity has been mentioned; other categories of patients also require very special treatment and handling from the nurse. Most people, when faced with a despondent and unhappy patient, endeavor to console him; they usually feel pity for him because of his condition. The nurse should avoid this type of response by adopting a firm yet kindly attitude. Her objective should be to help the patient to channel his aggressions outwards in a constructive fashion. Equally important is the nurse's attitude to patients who, along with their physical handicap, give evidence of organic mental deficiency in the form of temporo-spatial disorientation, memory loss or concentration difficulties. Patience, understanding and reassurance are necessary in the care of these patients. They should not be confronted too bluntly with their limitations.

Many other factors could be mentioned in this examination of the role of the nurse in a rehabilitation centre. The intention has been, however, to present only the most essential and most fundamental responsibilities of her role with regard to the emotional problems and conflicts of all who are physically handicapped. Because of the frequence and variety of emotional problems afflicting these disabled persons, it is now recognized that the nurse who works in a rehabilitation centre should have special psychiatric preparation. This concept of the nurse's functions and responsibilities is not merely an idealistic one; on the contrary, it is empirical. It is to be hoped that this concept will eventually be accepted as part of a more progressive view of rehabilitation.

If anyone tells you that a person speaks ill of you, do not make excuses about what is said of you, but answer: "He was ignorant of my other faults, else he would not have mentioned these alone."

—EPICTETUS

MEDICAL SOCIAL WORK

in a Rehabilitation Setting

JOAN M. AMBROSE, A.M.I.A., P.S.W.

In a rehabilitation institute there is a great deal to be done for the patient by the whole medical team in helping him to overcome his disability or to live with it, and the medical social worker has an important role to play.

When a patient goes into hospital his whole life is disrupted; his freedom is curtailed and everything is planned for him. A Rehabilitation Centre is half-way between hospital regime and a return to the community. While the patient is not entirely free, he is encouraged to participate in his treatment and to become as independent as possible. The social worker is the link between the patient and the outside world. She is the one member of the team who is particularly concerned about his family and how they are managing at home during the time he is on treatment.

The functions of the social worker are twofold. First, to give the doctor and other members of the rehabilitation team information about the patient, such as family particulars, education and employment history, financial circumstances and the social milieu generally. Second, to help the patient and his family adjust to his changed way of life and to support him emotionally through the difficulties encountered during the period of treatment and subsequent discharge home.

The patient may be seen when he first comes to the Centre for screening or he may be referred to the social service department at any time during his treatment. At this point, a social history is taken. At the same time a relationship is established between the social worker and the patient. It is this relationship which forms the basis of any casework services that may be given later.

It does not require a great deal of imagination to understand how traumatic can be the onset of sudden physical disability. The well established business man, driving off to work in the morning, suffering a stroke and being half paralyzed and speechless by the evening; the young school child struck down with polio in the space of a few hours; the busy housewife injured in a car accident and turned into a helpless quadriplegic by nightfall. These examples are representative of patients who are being treated in any rehabilitation centre daily, in any part of the world. Realization of the permanence of their injuries may set in when they have received the first few treatments and when, contrary to all their hopes, they hear that they will be rehabilitated to a wheelchair life, since walking will never again be possible.

Such realization may bring a number of reactions. No two persons are alike in this respect. All that one can say with any certainty is that resignation never seems to appear at first; bitterness, anger, aggressiveness and a terrible sense of frustration and lack

of desire to live are the reactions most often seen. It is at this time, particularly, that the social worker can try, by giving support, to help the patient maintain his morale until a later equilibrium is reached.

Naturally, a great many tangible services will be made available when necessary. Financial assistance and advice as to where to apply for this will be given to the patient's wife. When the patient is a housewife, arrangements may be made through a family agency to supply a visiting homemaker or even to find foster homes for the children, if necessary.

Families are interviewed to discuss discharge planning, which involves so much more than just finding out where the patient will go. The wife of a hemiplegic patient will often be most distressed and fearful of the change in her husband. It must be pointed out how independent he has become through the self-care program. If there is no likelihood of his returning to work it may be necessary to discuss with her the possibility that she should seek a position while he stays home and does the housework. This entails a complete reversal of the roles of breadwinner and homemaker and is fraught with psychological pitfalls.

So much depends on the personalities of the patient and his kin before the changed pattern of their existence fell upon them. So it is, too, with those patients who have to wear an artificial limb. Some take to it like a duck to water but others never get accustomed to this foreign material which is henceforth a part of their body. With women in particular, the cosmetic appearance plays a large part in their ultimate satisfaction and use of the limb. Here again, their fears and doubts may be aired with the social worker and possibly another interpretation given to them. It is obviously possible to adopt one of two attitudes — optimistic or pessimistic: a stump can be revolting and its exposure indecent, or it may be looked on as well healed and ready for a prosthesis. It should be borne in mind that there is always a period of mourning for the loss of a limb just as we mourn the loss of a person who has been close to us.

What contact does the social worker have with the nurse? The answer should be a very close contact indeed. We might even say that next to the doctor, the social worker should be the one to have the most frequent contact with the nursing staff. For instance, in the matter of the patient's relatives, the social worker sees them by appointment and infrequently, since they usually visit the patient after treatment hours. The nurse, on the other hand, may see them every evening and at weekends. At visiting times, the nurse may be the only member of the rehabilitation team that an anxious relative can speak to, and so many precious bits of information can be imparted by the nurse both to the social worker and the patient's relatives or friends.

The nurse is in an advantageous position, also, to watch for signs of depression, changes in behavior, and the general attitude of the patient towards his treatments and subsequent discharge. For this reason, the social worker would be well advised to consult the nurse in charge of each ward so as to follow any important developments. In her turn, the nurse may gain some insight into why a patient is particularly agitated or depressed, by hearing of the social problems and difficulties with which this particular patient is beset. It cannot be pointed out too strongly that difficulties will arise if the nurse lets herself become too emotionally involved in the domestic and personal affairs of the patient and she should not unwittingly become a sort of nurse-social worker combined. This remark, unfortunately, could be applied to many of the other disciplines in a rehabilitation setting. To be sure, it is an excellent thing to want to help people, but just as a plumber should not try to fill dental cavities, so a person untrained in social work should not attempt to enter the complex field of patient-family dynamic relationships.

To conclude on a constructive note. What are the problems existing to prevent the smooth working of a good nurse and social worker relationship, and what can be done to rectify them? There is only one difficulty which may have to be overcome and this is the lack of communication between the two professions. While a social worker

has a pretty good idea of what a nurse does, the reverse cannot be said. It is therefore up to the social work profession to explain the functions of a medical social worker both in lectures to the nursing profession and by individual workers who are attached to specific wards and medical clinics making their functions and limitations known to the nursing staff.

The Education of Handicapped Children

THÉRÈSE DIGNARD

Education — a doorway to independence.

Educational Services

a. *Organization:* Following the poliomyelitis epidemic of 1959, the Rehabilitation Institute of Montreal added a school to its facilities. The epidemic brought about the hospitalization of a number of children during the school year. Provision of a teacher by the Catholic School Commission of Montreal enabled them to keep up with their studies.

b. *Admission of handicapped children:* About 40 children of normal or near normal intelligence, but all exhibiting physical disability to some degree, are entrusted to the teacher each year. These youngsters may be suffering from amputation; cerebral palsy; spinal abnormalities; congenital anomalies; paraplegia; speech difficulties; slow learning, etc. They come from all areas within the city of Montreal and from within and outside the province of Quebec. Some attend the Institute as outpatients, others require hospitalization.

c. *Course of study:* Teaching is carried out in a large, well-appointed classroom. Each weekday, school age children from first to ninth grades attend classes for an hour or longer. The child's doctor decides about his attendance and class-time is arranged to avoid conflict with treatments. The teacher may find herself confronted, at one and the same time, with two, four or even six students at different levels of learning. She carries out the program of studies currently in effect within the schools of the Commission. Homework to be done in the child's hospital room or in his home is part of the plan. Books are provided by the Commission and are loaned to the students.

The teacher also spends half an hour each day with children confined to their rooms. She plans independent study for them and supervises their work.

Education and Nursing

a. *Education:* The rehabilitation of

handicapped children provides a huge field for investigation. Intellectual development is a vital part of the program and offers unlimited opportunities. Through education the child will achieve independence of mind, at least, and will find a place for himself in society. Education provides the best remedy to the distressing problems of handicapped children. The teacher is largely responsible for developing the child's sense of curiosity; rousing his desire for learning; awakening his interest in study; encouraging his initiative and helping him to devise a way of life compatible with his physical condition. The child must eventually assume his place in society regardless of his disability.

It is essential that the handicapped student should be free of harmful complexes, apprehensiveness and embarrassment which would hinder full intellectual development. In the Institute's classroom every effort is made to provide students with opportunities to use initiative and to assume responsibility so that, in later life, they will be able to act resolutely, self-confidently, enthusiastically.

b. *The nurse and the teacher:* The education of the handicapped child has the qualities of a mission. Success will be achieved to the extent that other responsible persons, in particular the nurse, support the efforts of the teacher.

The capable nurse knows how to soothe and reassure a nervous, upset little patient. She takes an interest in his studies and congratulates him on his successes. The handicapped student needs to have implicit confidence in his nurse. He must know that he can turn to her for assistance as he requires it. It is impossible to shield the child from all difficulties but if he is well-prepared he can deal with them more easily. For this reason development of character and, in particular, will-power is especially important. Because of her close relationship with the child, the nurse is able to play an important part in helping him to accept and to overcome his handicap. Once this is done, half the battle is won and the future holds no terrors.

Conclusion

The Rehabilitation Institute of Montreal in line with its philosophy of humanitarian service seeks, through its organization and services, to achieve rehabilitation of the *whole* person.

IN THE GOOD OLD DAYS

(The Canadian Nurse — MARCH, 1923)

In feeding patients who have typhoid fever, we feed with the idea, not only of furnishing energy and material for tissue repair, but also of establishing an intestinal flora which is antagonistic to B. typhosus. To this end are given B. acidophilus milk, lactose and dextrinized starch.

* * *

One of the greatest advancements in science is the sending of photographs by wireless. As yet this has only been possible over short distances, but it is predicted that the time will soon be here when illustrations can be sent by wireless as easily as words are now. A newspaper correspondent can transmit the photographs he has taken with the same facility as he sends his news report.

The total number of deaths from tuberculosis is greater than the combined deaths from measles, whooping cough, diphtheria, scarlet fever, and smallpox. During the period of the Great War, some 40,000 Canadians died gallantly in battle, and this gripped the attention and interest of every citizen. But during the same period, little or no interest was aroused by the fact that some 43,000 died needlessly and wastefully from tuberculosis. Between the ages of 20 and 29, the deaths from this disease are one-third of the deaths from all causes. In 1921, the nine provinces of Canada lost more than 81 people in every 100,000 from tuberculosis, or a total of 7,694 people. This means that one in every 14 deaths was due to this disease.

The Importance of Eating

E. HENDERSON, B.SC., H.EC.

All the treatments given to rehabilitate a patient are useless if he does not have the will to live which good eating stimulates.

In his book *The Importance of Living,* Lin Yu Tang describes the Oriental guest's method of showing appreciation for a well-cooked dinner: he smacks his lips, burps repeatedly, and the finest accolade of all, of course, is a well-defined belch!

To our western minds this would seem to be the height of discourtesy. It all depends upon one's point of view. Irrespective of viewpoint, custom or training, however, every man, woman and child — from east to west, from north to south, rich or poor, erudite or illiterate, sick or well — knows that the importance of eating cannot be overlooked.

Nowhere is this importance of eating more essential than in a hospital. All the medical skill in the world, all the potions and medicaments put together, all the tender and devoted care of nursing come to nought if, for one reason or another, the patient does not regain his appetite and the will to live which good eating stimulates.

It is not surprising, then, that in its building plans the Rehabilitation Institute of Montreal called for first, a bright, cheerful and colorful dining room and second, a gleamingly clean, up-to-the-minute kitchen to give carefully selected chefs the incentive to create the finest of meals for the Institute's most important customers, its patients.

Suffice to say, the stipulations were well met but the decor is merely the facade of the importance of eating. The most beautiful dining room in the world cannot long be successful if the quality of its food leaves much to be desired, or if the memory of a delicious meal is spoiled because of a poor cup of coffee. From long experience, the Institute knows, too, that the appetites of sick people must often be cajoled and tempted in order to help them in their fight toward renewed health and strength.

Experience has also taught that patients at the Rehabilitation Institute are not quite like those in an ordinary general hospital. There, the problem is the fastest possible recovery from illness. At the Institute, on the other hand, the patient must not only be helped to recover from illness or accident but he must be assisted to overcome the handicap which his illness or accident has left in its wake. Last, but by no means least, he must be helped to a renewal of self-confidence so that he may once more take his useful and rightful place in society.

Fitting like a well-turned glove into the picture of nursing, physiotherapy, social service, occupational therapy, psychology and psychiatry is the dietary department. Unlike the average general hospital which has neither the need nor the provision for a patients' dining room, ambulatory patients at the Institute are encouraged to use its cafeteria facilities whenever possible.

These facilities, of course, have been designed with the handicapped in mind. Walking patients, for instance, with possibly limited use of hands and arms, will have their trays prepared for them and be helped to a table. Those in wheel chairs, on the other hand, will make their own selection from the low counter and wheel themselves to tables specially designed to allow for an easy and comfortable fit of the chair. Low tables and chairs are available for the small fry and the diet-

ary department's counter girls are ever ready to see that these smaller appetites are both encouraged and satisfied.

For those patients eating in the wards or in their rooms, trays are prepared from the kitchen and placed in an electrically controlled truck (one side for hot food, the other for cold). Then off they go to serve food that is piping hot or refreshingly cold. Finally, for those patients whose particular handicap may lie in the limited use of hands and arms, there is a specially-designed cutting fork so that with only one hand they are able to dissect their food into appropriate bite-sized pieces.

As well as patients, a good 50 per cent of the staff and nurses use the Institute cafeteria. This is particularly true of the noon meal where they enjoy exactly the same menus as do the patients. There is, as well, a charmingly decorated private dining room for doctors and senior staff, all of whom partake with gusto of the same food.

It would be a mistake, however, to think that the Institute's food service could ever be suitable for healthy adults or the ever-hungry male in the armed services. Many of the patients require a variety of special diets, ordered by their own physicians, just as would be found in a general hospital. There is even the occasional unusual diet necessitated by loss of teeth or malformations of the mouth. Meals, then, must be as attractive and palatable as possible within the confines of a budget and the restrictions of a diet and, in all cases, must be based on sound dietetic principles which can be best summed up in Canada's Food Rules.

The most important part of the dietary department's function, however, is to fit into the philosophy of the Institute as a whole which is to refit patients for their eventual return to their homes and their place in society. Because the stay is usually longer than in a general hospital it is most important for the dietitian to visit with the patients, to be able to explain the necessity for special diets, and in many cases, to encourage and teach patients to follow sound dietary principles on their own initiative. For instance, there is the record of the ten-year old boy who would not touch milk but, on the contrary, was a real tea-granny. The milk was dressed up a bit and with some coaching and the example of other children all around him, our young friend was soon polishing off three glasses of milk at every meal.

It is incidents of this nature that make the dietary department's task worth while, that enable it to face each day's difficulties with cheer. In a nut shell, the dietary department is glad to be able to follow the philosophy of the entire Rehabilitation Institute where each department does everything possible to see that the patient's life is more than durable, the emphasis being on a warm welcome, good cheer, and an earnest desire on the part of everyone concerned to *get well quickly*.

Coming!

IN

APRIL 1963

THEME: CANCER

Bryant — Modern Methods of Treatment of Malignant Diseases.

Miller — These Four (Home Care for Cancer Patients)

Whiteford — Nursing with INHS in the Saskatchewan Region

Baribeau — Leukemia

Macdonald — Radiation Protection in Diagnostic Radiology

Hornick and Howard — A Hospital Postpartum Teaching Program

plus additional material

THE MEDICAL ARCHIVES

MARIE-THÉRÈSE BOURBEAU, R.R.L.

The records department of an institution provides information for present use and inspiration for future research.

INTRODUCTION

Increasingly greater use is being found for the nurse's skills. Accordingly, she must have an over-all idea of the administration of the institution where she is employed and some understanding of the various services offered. Undoubtedly the medical records will interest her and, in fact, a number of nurses have become medical archivists.

The medical archivist, through her specialized preparation, is completely familiar with the organization and administration of a medical records department in conformity with the requirements for hospital accreditation and the needs of the institution's medical personnel. She is responsible for:

a. Care and preservation of medical documents. These records must be readily accessible through up-to-date index systems.

b. Checking documents for completeness before filing;

c. classification of records according to accepted medical and surgical nomenclature;

d. compilation of statistics as required by the institution;

e. in some instances, organization and care of the medical library.

The archivist must be progressive in her outlook, must keep herself informed of new developments in order to provide the most effective service. Sheer habit must be avoided and methods should be examined frequently for the elimination of outmoded routines. Finally, the archivist must possess the skill and personal qualifications necessary to maintain good relationships with heads of all departments.

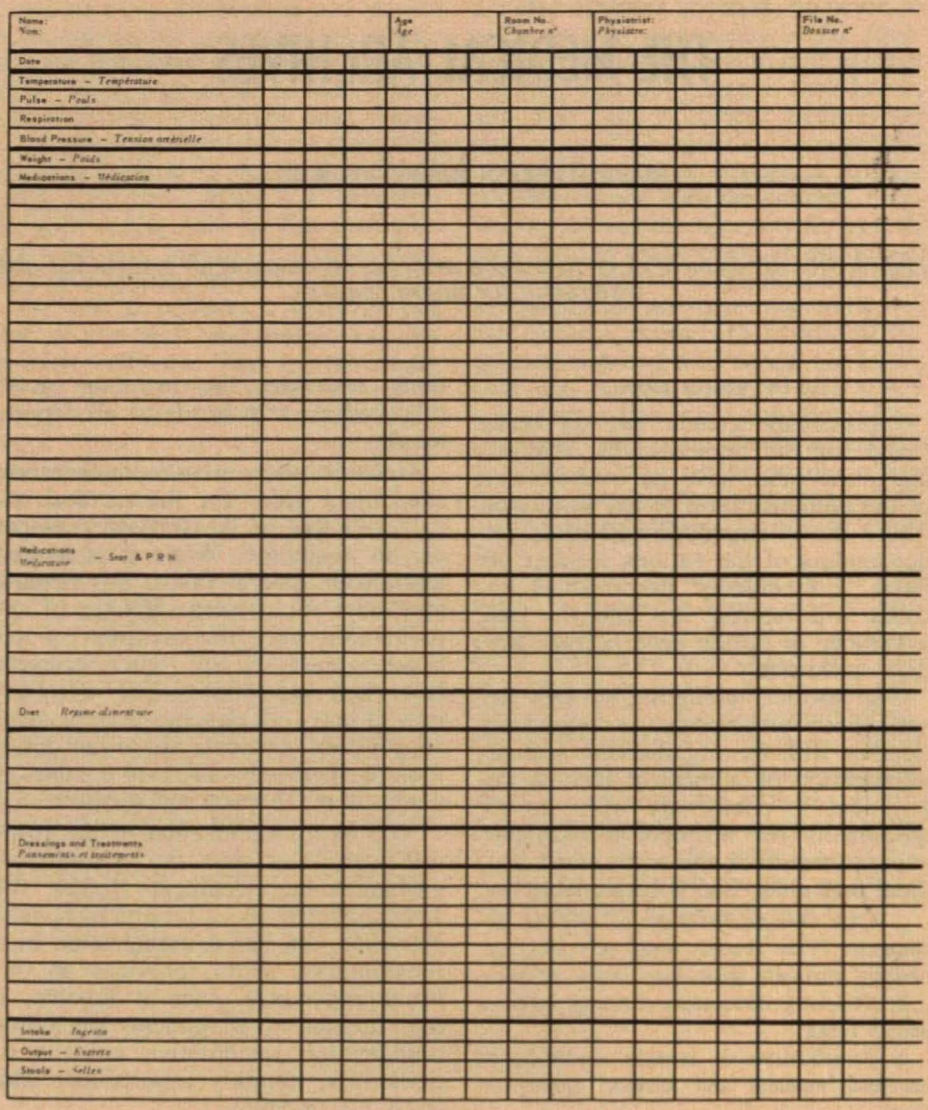
Genuine pride in its administration can win a place for the medical archives as one of the strategic services of the institution. While it is looked upon with general favor, this department also rouses some feelings of apprehension since the archivist, of necessity, must set up rather stringent rules and regulations. The effectiveness of her work depends upon general cooperation. The exercise of her duties requires patience and tact equally as much as persistence and method.

The basic organization of the Institute's archives and the quantitative evaluation of documents follow the same patterns as in general hospitals. However, the initial organization in a rehabilitation centre provides an unusual experience since it involves a daily census of *all* patients (including outpatients), quantitative analysis of discharges, monthly reports and case study classification.

The Institute has adopted the single file system in which all information and correspondence concerning a patient, regardless of whether he is hospitalized or an outpatient, is compiled in one master document, with the patient retaining the same admission number. Correspondence related to the Institute's patients tends to be much more voluminous than in general hospitals: Summaries of documents required for admission purposes; financial arrangements concerning pros-

REHABILITATION INSTITUTE OF MONTREAL—INSTITUT DE RÉHABILITATION DE MONTRÉAL

NURSES' TREATMENT RECORD — RAPPORT DU NURSING



The following additional forms are used, as noted:

(a) Temperature — Température
(Form R.I.M. 91)

Temperature and blood pressure are recorded once a day. When more frequent recording is required, Form R.I.M. 91 is used. The dotted lines permit a clearer graph.

(b) Blood Pressure — Tension artérielle
(Form R.I.M. 93)

This form is used for patients requiring frequent blood pressure readings.

(c) Nurses' Notes — Observations de l'infirmière
(Form R.I.M. 90)

Only relevant observations are charted: patient's behavior and cooperation; progress noted in any area of activity, incidental or accidental. Upon discharge, the exact time must be noted; specific mention should be made of the identity of the person accompanying the patient; the patient's general condition should be recorded.

thetic appliances; arrangements for job placement; requisitions to social agencies, etc.

It should also be noted here that the initial report concerning the result of the physiatrist's evaluation plus a summary of the patient's file is forwarded on the patient's discharge to the referring doctors.

The Hospitalized Patient

As soon as a patient is admitted to the Institute, his file is sent to the head nurse's office. The forms used by each department are distinguished by color so that files can be examined much more readily and information obtained more speedily.

When these various forms were being prepared, considerable care was taken to have them completely bilingual. This situation is unique, at least for Canada, if not for the world.

In summary, nursing forms differ somewhat from those in use in general hospitals, at least in regard to the type of observation and their frequency. In principle, those eligible for rehabilitation are in the convalescent stage and, as a result, the nurse's observations need not be recorded daily.

Nurses form a very important part of the rehabilitation team. In the doctors' eyes, their observations have vital significance.

On discharge the patient's file is turned over to the archivist to be signed off before it is passed along to the physiatrist for completion.

The Outpatient

Outpatient records are stored in the archives once the history has been completed and requisitions filled. The doctors only are permitted to keep outpatient records in their offices for further study or for the preparation of reports. Other personnel are free to consult patients' files in the archives at any time.

A special alphabetical file has been set up to keep track of documents out on loan. As soon as a document changes location, the records department is notified. Reports from the various units are all deposited in the archives. As soon as they are received they are sent with the appropriate file to the physiatrist who checks and initials each form. Classification is never done until each patient's chart has been completely checked, properly signed and initialled. Supervision of this extensive circulation of records assures each team member rapid access to information as required.

Statistics

Two reports have special significance:

1. Daily total census (in-and out-patients), and of individual units. The reports from the wards reach the records department late in the afternoon.

2. The monthly report includes a table of discharges that indicates the prevalence of the main conditions treated or evaluated; the result of treatments; the reasons for non-acceptance of some patients; the number of follow-up examinations and consultations, etc. as well as various percentages and means. The medical board has approved this monthly report (prepared by the committee on statistics) and it is presently used as a basis for preparation of other reports.

Classification

The *Standard Nomenclature of Diseases and Operations* is used for classification purposes. Diagnoses and sequelae are classified since the latter are the raison d'être of the Institute. Emphasizing the basic importance of classification is unnecessary. It has provided the starting point for various topics of research within the Institute.

Conclusion

In the attainment of the objectives that the Institute has set for itself, medical records are one of the essentials. The personnel of the department must be constantly alert. Obviously if the archivist is persistent in her efforts to secure complete cooperation from everyone concerned, it is done solely with the aim of providing essential and pertinent information at the opportune moment without which no medical institution could function smoothly and efficiently.

BIBLIOGRAPHY

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(Continued from page 238)

Mathilde Dumpich (Cottbus Hospital, Cottbus, Germany '50) died early in 1962. Mrs. Dumpich was on the staff of the Charles Camsell Hospital, Edmonton at the time of her death. Her first appointment when she came to Canada was to the staff of the Elk Point Municipal Hospital.

* * *

Sarah Agnes Dunlop (St. Joseph's Hospital, Sudbury, Ont. '24) died in Ottawa during 1962. She had engaged in institutional nursing.

* * *

The alumnae association of the Public General Hospital, Chatham, Ont. pays tribute to the memory of the following graduates: **Gertrude (Hillman) Eggins** '23 and **Ethel (Laird) Kinnard** '13.

* * *

Nancy Rachel (Rimmer) Franklin (The Hospital for Sick Children, Great Ormond St., London '37, Addenbrooke's Hospital, Cambridge, England '41) died in Winnipeg on November 18, 1962. Mrs. Franklin had been forced to retire from her position as director of nursing, The Children's Hospital, Winnipeg shortly before her death. During the years 1948-60 she was on the staff of the Montreal Children's Hospital in supervisory, teaching and administrative positions.

* * *

The alumnae association of Owen Sound General and Marine Hospital, Ont. pays tribute to the memory of **Jean Elizabeth (Sword) Girvan** '14 and **Georgina (McReynolds) Wilson** '18.

* * *

The alumnae association of Calgary General Hospital has recorded the loss through death of several members: **Alice Mary (Cartier) Farrow** '19; **Alberta Holifield (Boyd) Hallman** '45 as the result of injuries in a car accident late in 1962; **Frances Ann Harvey** '30 and **Ruby Grace (Novis) Heath**, matron of Canmore Municipal Hospital, Alta.

* * *

Sylvia Rita (Saari) Heinonen (Suburban General Hospital, Bellevue, Pa. '25), an Ontario nurse, died in Toronto during 1962.

* * *

Jean Alexandra (Collins) Hodgkiss (Toronto East General Hospital '45) died late in 1962.

* * *

Helen Doreen (Arbuckle) Johnston (Brockville General Hospital, Ont. '54) died during 1962.

The alumnae association of Toronto General Hospital records the loss through death of the following graduates: **Marion Elise (Miles) Kelly** '10; **Mabel McKnight** '17; **Harriette Shaw Wilson** '27.

* * *

Marie Jeanne Lacroix (Hôpital St-Vincent-de-Paul, Sherbrooke '50) died in November 1962.

* * *

Doris Marie Latornell (Royal Jubilee Hospital, Victoria '38) died during September 1962 as the result of injuries received in a car accident. She had served with the RCAMC during World War II and had joined the staff of the Colonel Belcher Hospital, Calgary following discharge.

* * *

M. Helena Leahy (St. Michael's Hospital, Toronto '30) died in Toronto in November 1962. Miss Leahy was engaged in private nursing.

* * *

Lenore (Shewfelt) Letienne (St. Boniface General Hospital, Man. '38) died in Montreal on November 19, 1962. She was on the staff of her hospital for 15 years.

* * *

Gertrude (Strong) Mahood (University of Alberta Hospital, Edmonton '32) died in Fairview, Alta. late in 1962.

* * *

Mary Manning (Holy Cross Hospital, Calgary '41) died in September 1962 from injuries received in a car accident. She was on the staff of the Aberhart Memorial Sanitorium, Edmonton, at the time of her death.

Eleanor Irene (Kelly) McGinn (Buffalo General Hospital, Buffalo, N.Y. '13) died in Toronto on January 4, 1963. She had engaged in institutional nursing.

* * *

Isobel (Carmichael) Mothersill, an Ontario nurse, died recently at Trenton, Ont. She had retired from industrial nursing.

* * *

Rosemary E. Motz (St. Mary's Hospital, Kitchener, St. Michael's Hospital, Toronto '58) died during 1962. She had engaged in institutional nursing.

* * *

The alumnae association of St. Joseph's Hospital, Hamilton pays tribute to the memory of: **M. Patricia Muldoon** '34 and **Agnes (Campbell) O'Keefe** '22.

* * *

Joyce Elaine (Fleming) O'Brien (Hamilton General Hospital, Ont. '54) died late in 1962.

VOLUNTARY SERVICES

FLORA MCD. BAPTIST

A brief outline of the basic aspects of volunteer services in a hospital, and the duties of a director of volunteers, which are applicable to all hospitals including a rehabilitation hospital.

Taking part in the life of our community is today an essential task. It is not a fad but part of our education in developing a sense of responsibility for the social, cultural and intellectual aspects of our lives.

This generation can look back to the depression years when we learned that the need for personal services was crucial and community action kept a community together. The war fought under the banner of freedom, pinpointed the same underlying motivation and made community service not only a social but also a national responsibility.

We now have entered upon a new era where, because of our rapidly growing population and the outstanding developments in medical science, the need to serve our Canadian citizens has created a rapid tempo in the expansion of hospitals and the building of new ones.

Montreal, renowned for its medical history, has kept up with this spate of hospital construction. The pattern of hospital administration has become so complex and the burden upon the professional staff so heavy, that a large responsibility is now being shared with volunteer services. Approximately 12 years ago, two of Montreal's largest teaching hospitals became the first in Canada to establish volunteer services within their administration. Foresight, shortage of hospital personnel and perhaps the threat of losing sight of the original purpose of a hospital were some of the reasons why these services were contemplated. Stimulated through professional interest and appreciation, volunteer services were thus established. To achieve their objectives, these services were brought in on a professional basis. They were to help promote the interest and understanding of the hospital within the community, to serve the hospital in whatever way the administration desired in their capacity as volunteers, and to raise money for desirable purposes beyond the budget of the hospital which would provide extra comfort and service to patients, nurses and staff.

A director of volunteer services was appointed as a department head, and the volunteer department became a unit within the hospital's administration. In this way, the highest possible standard of volunteer service could be provided. Policies and standards for the administration of the department were settled and the duties of the director outlined.

In a very short time, volunteer services proved to be of inestimable value to the hospital and patients. Today, most hospitals have established similar volunteer departments. It is only on rare occasions we hear of one without.

Keeping in mind that these services also provide needed supplementary service to the hospital and patients, the duties of the director are many and will not be covered in detail. However, to mention a few basic ones, the director must *plan* for the proper function-

ing of the department. She must know the hospital's administration, how each section, from the Board of Governors down, connects through the proper channels for efficient administration. She must know the department heads, the function of each individual department and the lines of communication to be followed from one department to another, through the proper individuals. The hospital policy as a whole and where the volunteer department fits in must be known before that department's own policies and standards are set up.

The physical aspects of the department are planned as to space required, equipment, etc., down to the actual work projects which are to be organized. Recruiting is the duty of the director, and her responsibility is greater if it is a new department being established, for she must start slowly; over-enthusiasm has to be curbed, otherwise coordination cannot exist.

An auxiliary can also help a great deal in recruiting. However, the best recruiter is the trained volunteer who, by word of mouth, can present a true picture.

The director may call upon the resources of volunteer service bureaus in recruiting volunteers, cooperating with the Public Relations Department of the hospital. Publicity can be a source. However, *newspaper* publicity has been known to create problems since it brings in volunteers not qualified for hospital work and it is a difficult public relations job to turn them down tactfully. Interviewing volunteers is a time-consuming duty which requires technique. To try to sell a volunteer a job is not advisable. When one is not enthusiastic and is persuaded, one generally ends up by leaving once the novelty wears off.

Good placement is more than a duty. It bears a great deal of the responsibility for whether or not the whole purpose of a volunteer department will be successful. Placement is the skilful and imaginative adaptation of individual differences. Each volunteer is guided toward the job that provides the greatest opportunity to develop her particular abilities.

Orientation of each volunteer is another responsibility of the director. She must see that the volunteer will feel a part of the hospital staff and where she will fit in. To the headquarters the new worker brings her work problems and the criticisms she may hear about the hospital or the department. That is where she learns the facts and can correct false rumors, etc. Her orientation is the key to good public relations.

The director makes arrangements with departmental heads for specific training of the volunteer and it is her duty to follow up continuously in supervising the over-all picture of volunteer work and her volunteers. She must be fair and ready to back her volunteer when necessary.

The director must gain the confidence of the professional staff in that their complaints, if any, regarding volunteers, be disclosed to her. She must weigh problems and straighten them out through her own initiative and decide whether or not any issue is serious enough to consult with her administrator.

One of her most time-consuming duties is preparing and submitting reports for the various individuals and groups concerned with the activities of volunteer workers in the hospital. Statistical reports are necessary also.

Verbal reports include facts about the cooperation, or not, of hospital personnel as well as information regarding recruitment of volunteers in the community.

Again, meetings are the concern of the director. They range from the annual meeting of the Board of Directors of the hospital, through the social meetings of community organizations, to the brief get-it-off-your-chest meeting with one or two unhappily assigned volunteers. Every meeting can be looked upon as an opportunity for gaining knowledge, for spreading information about the volunteer services and for the promotion of good public relations.

The types of services rendered by volunteers are varied and numerous. Many times the quality of work done is far better since it is done through personal interest rather than for pay.

The volunteer, as a member of the team, finds greater satisfaction in her work at the Rehabilitation Institute through personal contact with the pa-

tient, whereas in a hospital, the same opportunity is not so great. The rehabilitation nurse initiates volunteer participation as part of her work. Caring for the diversional needs of her patients is a part of rehabilitation. Volunteers and staff, all work as an organized partnership complementing each other towards achieving a common goal.

THE ROLE OF A RESEARCH DEPARTMENT

E. DAVID SHERMAN, M.D., F.A.C.P.

The scope of a research program is outlined in broad strokes.

The research we do today will determine the type of medical practice which we carry on at the Clinic tomorrow.

WILLIAM J. MAYO

Medical rehabilitation has aptly been termed by Rusk as *the third phase of medicine,* following preventive medicine and curative medicine and surgery. It is the period when the fever is down and the stitches are out. There are, of course, elements of medical rehabilitation in the first two phases just as the elements of those two are always present in medical rehabilitation.

In marked contrast to convalescence, in which the patient is left alone to rest through the period while time and nature take their course, medical rehabilitation is a dynamic concept and action program. Effective rehabilitation depends upon the skills and services of members of multiple disciplines under the direction of the physician who has the responsibility of integrating the concerted efforts of the rehabilitation team.

The objectives of rehabilitation medicine are to eliminate the physical disability or to alleviate it to the greatest extent possible, and the retraining of the person so that he can live and work, commensurate with his residual disability, to the best of his capabilities.

Fundamental to the effectiveness of all the component disciplines of rehabilitation is the adequacy of a Research Department, whose long-range goal is the attainment and improvement of physical well being, intellectual performance and the adaptability of various skills. Medical research can best be defined as the search for solutions to problems by means of the study of normal or disturbed biological proceses in patients. Because it involves contact with patients, it is then termed clinical research. Many complex problems exist in the care and treatment of the handicapped, relative to the underlying specific condition responsible for the disability. The search for solutions to these problems must be embodied through a dynamic and vital research program. Research in the general area of physical medicine and rehabilitation in Canada has been sporadic and isolated in character.

Being cognizant of and sensitive to the needs of a research program in the rehabilitation field for some years, the medical team of the Rehabilitation Institute of Montreal enacted the role of a *catalyst* and initiated measures that culminated in the establishment of

a Department of Research by the Board of Directors on June 1, 1962.

The Department of Research is designed to ensure a consolidated and integrated program to include the participation of various disciplines within the confines of the Institute; physical medicine, psychiatry, social service, occupational therapy, physical therapy, speech therapy, psychology, guidance, placement and prosthetics.

As the Department of Research will also embrace educational aspects, it is hoped that facilities in the future will be available for selected residents and fellows to spend a year in research during the course of their training. A Journal Club for reporting and discussing current literature, and seminars for the presentation of scientific papers by the residents will be gradually introduced. It is not being unduly optimistic to hope that the inauguration of these measures will ultimately lead to the creation of postgraduate programs for the medical profession.

Several research projects have already been formulated and submitted to granting bodies.

Scientific advances in knowledge have increased the life span. With these advances the greatest problems confronting medicine today are chronic disease and disability in an aging population. Though the youngest of all specialties in its present total concept, physical medicine and rehabilitation offer a tangible contribution to the solution of this baffling medical-social-economic enigma.

A concept has been formulated concerning priorities in specific areas which could become the subjects of study projects during the next few years, based upon the large and varied experience of the staff of the Rehabilitation Institute of Montreal.

1. Special attention will be given to demonstrating the value of a closely integrated and cooperative effort of all the various disciplines concerned in rehabilitation as the key to a complete and successful rehabilitation program.

2. The co-existence and relationship of independent rehabilitation centres and departments of physical medicine and rehabilitation in general or special hospitals will be studied as to their respective roles in an over-all provincial rehabilitation scheme.

3. The question of prosthetic and orthotic appliances will continue to be studied and their manufacturing under strict medical supervision will be re-evaluated.

4. Progressive investigations will be encouraged concerning the psycho-social and vocational aspects of rehabilitation in all groups. The objectives would be:

(a) The development of new or improved information, methods and devices for use by the several disciplines in the rehabilitation of the handicapped;

(b) the creation or identification of new job opportunities for the disabled;

(c) increasing the effectiveness of existing programs and stimulating community cooperation and effort;

(d) providing new professional information and ideas to administrators to aid in developing and expanding.

5. The important factors underlying motivation will be investigated in the area of social security assistance and disability allowances.

The aforementioned concept indicates some of the potential areas of research in the general area of rehabilitation. The value of contributions of this nature to existing knowledge and its benefits are obvious and do not warrant further comment.

Dr. Bayard T. Horton, of the Mayo Clinic, stated in a publication:

The desire to learn, to investigate, to explore the unknown, is an integral part of man. Research erodes the barriers of the present — a break-through follows, and new horizons come into view. It is a never-ending process. Creative work is man's greatest opportunity, his greatest satisfaction. The final reward for a good piece of work is an increased opportunity to do a better piece of work. This is the romance of medicine.

If you would improve, be content to be thought foolish and dull with regards to externals. Do not desire to be thought to know anything; and though you should appear to others to be somebody, distrust yourself. For be assured, it is not easy at once to keep your will in harmony with nature and to secure externals; but while you are absorbed in the one, you must of necessity neglect the other. — EPICTETUS

ASPECTS OF PUBLIC RELATIONS in Medical Institutions

MARIE LACHANCE

Who exerts the most important influence in every hospital's public relations program? The nurse, of course.

The logical questions that come to anyone's mind when hearing about public relations are: "What exactly is public relations? What does a public relations officer do?" and "What does it take to be a public relations officer?"

In hospitals, public relations are primarily a management function whose purpose is:

To interpret policies and objectives of the hospital to the public, foster attitudes of confidence and respect in the hospital on the part of the community and interpret the public's opinion of the hospital to hospital authorities.*

A hospital needs public support and understanding. It is not enough to serve the public well. The community must be made to realize what is being done. That is, in a nutshell, the work of the public relations officer in a medical institution. As for the qualifications required of a public relations officer, standard procedures do not exist. The person holding that office may be a college graduate, a journalist (journalism is definitely an asset) or somebody with previous experience in advertising. The ability to write is a compulsory qualification. In addition, in a city like Montreal and a province like Quebec, the knowledge of at least two languages is required. At the Rehabilitation Institute of Montreal bilingualism is a must.

When illness strikes or an accident happens everybody knows what steps to take. The suffering patient is automatically rushed to the hospital where it is expected that doctors will treat, cut, mend and repair. Soon after, the patient will be returned home. But, sometimes, following the ordeal, a strong healthy body will be left weak and disabled. What happens then?

The answer, of course, for many of those cases, is rehabilitation. As applied to the disabled, rehabilitation is, by definition: The restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable. It serves as a stepping-stone between acute hospital treatment and return to normal or paranormal life.

The Rehabilitation Institute of Montreal, as others, avoids duplication or competition with general hospitals and existing community services. On the contrary, a well organized centre helps the hospital as it relieves medical and surgical wards of long-standing chronic cases. Also, because a number of complex handicaps are infrequently met, it is evident that all hospitals cannot provide every specialized service, staff and equipment.

Since the field of rehabilitation is

* *Job descriptions for hospitals.*

relatively new, comparatively little is known about it. Therefore, before letting people know that the Institute exists and that its services are available to everybody regardless of race, color, creed or means, a basic knowledge of rehabilitation must be taught. To interest the general public and to foster attitudes of confidence and respect for the Institute, requires a planned public relations program that makes use of various means of communications, the basic channels being: the spoken word, the written word and audio-visual means.

At the Rehabilitation Institute, a strong accent is placed upon conducted tours. The centre being the first of its kind in Canada, it is rather important to have people come and see for themselves what the setup is like and what is being done for the welfare of the handicapped. This form of public relations is most profitable as it combines the spoken word with audio-visual means. Societies, groups, clubs, etc., are all very welcome to visit or to hold their meetings at the Institute. Several rooms of various size are available, free of charge, for meeting and conference purposes. Furthermore, speeches may be delivered by various Institute representatives to business, welfare and service clubs who are very much encouraged to utilize the speakers, as are radio and T.V. All those activities help to stimulate interest and insure public understanding and support of the Institute's objectives and needs.

Many opportunities are open for telling the story in writing. Newspapers never refuse newsworthy events, editorials or picture stories. Magazines, as well as medical and scientific publications, provide numerous occasions for any hospital to publish articles. In addition, at the Institute, a bilingual bulletin is issued monthly. Its circulation at present averages roughly 600. It is edited by the public relations officer and sent to hospitals, companies, groups, clubs and individuals from near or far who are interested in rehabilitation. It tells of plans, both immediate and future, for Institute activities and achievements. In order to help promote better employee relations, a special *home edition* of the bulletin is distributed to staff members. This edition contains staff news, social club activities, bowling league results, etc. Patients' handbooks, brochures and other literature are additional methods of telling the public the full story, which at the Rehabilitation Institute differs somewhat from that of other hospitals due to the specialty of treatment involved.

Last but not the least of public relations tools, is the visual education. Mention has been made of the importance of conducted tours. Simple posters, exhibits and interesting displays shown to the public either within an institution or in community establishments exploit this medium more thoroughly as does the showing of films and slides. Although very much has already been accomplished in the field of public relations much remains to be done and this third aspect has yet to be expanded. In fact, in public relations, one can constantly explore new fields of endeavor. The possibilities are endless, but everything cannot be undertaken at once. Public relations is essentially a form of public education. One does not educate overnight.

Everyone connected with the Institute, as with hospitals, helps shape the over-all public's picture of the establishment. Special care must be given to the selection of telephone operators, elevator operators, personnel of the admitting office, etc. Even more important is the nurse who is in daily and constant contact with patients. Sloppiness, surliness and disinterest in the work, even by one single member of the staff, creates a bad impression for the whole hospital. What people see and hear, as well as how they are treated as patients, will influence their opinion of the institution. Since it is recognized that the most effective method of establishing a sound public relations program is through the spoken word of satisfied patients, the nurse becomes a major public relations officer and on her shoulders lies the good or bad reputation of her hospital.

The office of government is not to confer happiness, but to give men opportunity to work out happiness for themselves.

— WILLIAM ELLERY CHANNING

THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

A Season to Reflect

While we are waiting for this month to fade out like a lamb, let's turn our thoughts back to that season which passes and is forgotten all too quickly . . . Christmas, the time of joy and sentiment and long-loved customs.

One of the most pleasurable of these is the Christmas card. We at National Office hold in affection the warm and thoughtful messages received from so many friends all over the world. Their beautiful cards brightened the office all through the season.

And, of course, another is the special get-together of those who work so diligently side-by-side throughout the year. Ours was a delightful pre-Christmas dinner with three equally delightful guests. Miss CHRISTINE LIVINGSTON, Dr. HELEN MUSSALLEM and Mrs. JEAN MARTIN (who recently left National Office) joined us in the charming old dining room of Le Cercle Universitaire d'Ottawa with our hostess Miss PEARL STIVER. Miss Livingston didn't forget her camera so this last Christmas with our Executive Director has been preserved in pictures and all of us will be able to reflect on Christmas 1962 in the months to come with fond memories.

What's New With Us

Miss THELMA PELLEY was the National Office representative to the Canadian Conference of Catholic Schools of Nursing held in Montreal late in January. The theme of that conference was "Institute on Nursing Service — Goal of Nursing Education."

Miss HELEN GRAY has returned after a lengthy absence and we are happy to see her back. From the pile of work that was awaiting her, we're not too sure how happy at the moment she is to be back!

We are also happy to welcome Mrs. BERYL DARLING to National Office staff. Mrs. Darling has rejoined the staff after six years with the Canadian Lumbermen's Association.

January 18th to February 25th was a time of meetings at National Office. Eight in all were held:

The Committee on Nursing Education; the Sub-Committee of the Public Relations Committee; the Canadian Joint Committee on Nursing; the National Office Auxiliary; the House Committee; the Sub-Committee on Finance; the Executive Committee and the Executive Secretaries Conference.

Future issues of the *Journal* will relate the results of these meetings.

A Reminder For You

Those of you wishing to apply for financial assistance from the Canadian Nurses' Foundation for study at the Master's and Doctorate level in the 1963-64 academic year, must have your completed application forms in the hands of the Executive Secretary, Canadian Nurses' Foundation, 74 Stanley Avenue, Ottawa, by March 31st.

As you know, eight grants are being awarded this year — six at the Master's and two at the Doctorate level.

The Selections Committee will be meeting the last week of May to study all applications and to select the eight who will receive this assistance.

Application forms are available through your National Office at 74 Stanley Avenue in Ottawa.

Tell Us What You Think

What would you like to read on these pages from your National Office? If you have any comments or suggestions, do write us. We would welcome your letters. In this way we will be better able to give you the information you want to receive.

What Price Security?

JUNE FERGUSON

Is a little sacrifice now too great a price for the future?

How often have you heard, "If only I knew then what I know now, I'd certainly do things differently?"

Unfortunately, too many times . . . often too late !

To most of us involved in the events of everyday life, the future is something that can always be reckoned with later; it is the present that is our prime concern.

These had been all-too-familiar words to the CNA over the years. To avoid such a pitfall for those in the nursing profession, many gallons of midnight oil were burned and many pencils sharpened to come up with a tailor-made security plan for the nurse . . . one that would see her living the life she wants — without wanting — when she sets aside her uniform, no longer able to practise her profession.

But what has happened since all of this hard work brought to life the CNARP close to five years ago?

Well, frankly not very much. True, some 300 nurses throughout the Association took advantage of the plan. But not an impressive number when you consider that more than 63,000 are eligible to do so.

Why ?

It may be that in the 17 comfortable years since the end of the war we have let prosperity go to our heads. In these years we have enjoyed a standard of living second to none. Never before has money come — and gone — as easily without more than a passing thought given to the fact that this situation could or would ever change. And perhaps we have felt secure and a little smug in our booming economy.

But however plain the facts may be that the situation has and is changing, it is difficult to convince us that the essence of our individual security is what we ourselves make it; that it cannot be assured by anyone else.

It is equally difficult to convince us that now is when we must decide to see things in the perspective of building for the future, whether we want that future without wanting and whether we are prepared to pay a price for it. Unquestionably, there is a price, as there is for anything worthwhile in life. But in the case of the nurse, it is a very small one indeed—the setting aside now of a few dollars a month for the satisfaction of knowing there will be no need to look back and say, "if only I knew then what I know now."

Or, it may be that we just haven't taken a good, hard look at the benefits of this plan brought forth with a great deal of research, study and investigation — a plan designed solely for the nurse which enables her to work where she wants , for whom she wants, even when she wants, and gives her the ad-

ded advantage of long-term investment in addition to saving. Unique features in themselves !

Let's take that good, hard look now.

First of all, it is a financially sound plan. It is operated under the expert advice of three leaders in their fields —the National Life Assurance Company, The Royal Trust Company, and the Bank of Montreal — who enjoy an enviable reputation for good money management with high average earnings. Their policies feature safety rather than speculation.

The CNARP is actually two plans in one. Plan "A" is designed for those of you who are self-employed; employed where no pension plan exists; or for those of you wishing to supplement your present plan. Plan "B" on the other hand is for those of you working for an employer who will join you in setting aside money for the future.

No one has been overlooked. The nurse in private practice, in the hospital and the agency; in industry, in the doctor's office and even the part-time nurse may participate.

Within each plan are two funds in which you may save and invest to your definite advantage — the insured annuity fund, managed by the National Life, and the common stock fund, administered by The Royal Trust Company. You may contribute to one or both the funds.

In the insured annuity fund provision is made for a fixed income at a stated age. The earlier you start, of course, the larger your pension for it is determined precisely at the time you join the plan.

Your contributions to the common stock fund are invested in a portfolio of common stocks of leading corporations, those determined by the experts to have the best opportunity for future growth. At retirement age the accumulated monies are transferred to the annuity fund and a pension purchased with your total savings.

Not only does this fund provide the possibility of doubling your pension, but through the long-term investment of your capital it also provides a hedge against inflation.

With the savings of a large number of individuals, sufficient money is accumulated to establish a diversified investment portfolio. It is this diversity that reduces the risk of large price fluctuations that might occur in a single stock, and is something which the individual could not achieve alone without an extremely large amount of money for investment. And there are other pluses to the CNARP.

Your contributions are deductible from your income tax. The rate of interest on contributions to the insured annuity fund is guaranteed at 3½ per cent . . . it is presently yielding 5¼ per cent. This, remember, increases with increased membership. Contributions to the common stock fund bring even greater dividends. Also, the plan allows for transfer from one employer to another who is enrolled in the CNARP, without a waiting period or loss of benefit.

Plan "A" is available for as little as $100 a year. You can, of course, contribute more. The first $100 saved in each year is placed in the insured annuity fund. What you wish to contribute in addition to this may be allocated to the insured annuity fund, the common stock fund, or divided between the two. Arrangements have been made with the Bank of Montreal to accept your regular contributions at any of their local branches and to transfer these monies to the plan without charge to you.

Under Plan "B" you contribute 5 per cent of your salary, which is deducted from your pay, with your employer contributing an equal amount. Here again, you may contribute more — up to 10 per cent of your salary. This will not increase the amount your employer contributes on your behalf, which is automatically allocated to the insured annuity fund. Your contributions may be placed in either fund or divided between the funds in any proportion you choose.

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Glimpes Into Hospital Nursing

MYRTLE S. BIBAUD, CATHERINE W. KEITH, JEAN H. MACDONALD, CALLA I. PARK, WINIFRED ROSCOE, *and* ELVA TAYLOR

An enthusiastic report about hospital nursing in the Foothills Region.

The Foothills Regional area includes Alberta, the Yukon Territory and the western portion of the Northwest Territories. We administer six hospitals in the Foothills Region. These are located at Edmonton, Whitehorse, Inuvik, Cardston, Gleichen and Hobbema. We also provide both bedside and preventive nursing care at numerous outpost nursing stations.

Each hospital is the centre for both treatment and community health programs. It is the headquarters for our public health, medical, nursing and administrative staff. This makes excellent liaison and follow-up care possible.

Charles Camsell Hospital, Edmonton

We would like to tell you about the two children's wards in this 500-hospital.

Ward Seven is a 63-bed unit, accommodating children up to 13 years of age who are under treatment for tuberculosis. The ward contains three large rooms, each with a capacity of 12 beds or cribs. Thus, during a long period of hospitalization, the child's need for companionship is fulfilled. There are nine smaller rooms five of which are designated for infants and toddlers. The other rooms are used for acutely ill patients or for isolation purposes.

Ward Eight is a non-tuberculosis pediatric ward. It has a capacity of 60 cribs with facilities to care for children up to five years of age. The children come from the Alberta reserves, the Western Arctic, the Yukon, and occasionally as far afield as Resolute Bay on Cornwallis Island. Those from outlying areas are referred by field doctors and nurses, R.C.M.P. detachments, DEW Line doctors and our own medical survey units.

When admitted, the children are very quiet, reserved and obedient. Many of them are unable to speak English. Usually the food is strange to them and they do not like it. Many have never before seen a bathtub, white bedding, polished floors, uniformed people, or any of the things common to hospitals. They soon adjust to the ward routine and lose much of their reserve, revealing their true, likeable charac-

(Ernest of Goertz, Edmonton)

ELVA TAYLOR

ters. They are honest, happy, intelligent children, appreciative of the smallest favors done for them.

Treatment in the Charles Camsell is both medical and surgical. The list of diagnoses is long and varied. The local people suffer mainly from otitis media, pneumonia, skin conditions, communicable diseases, gastro-enteritis and malnutrition with its attendant rickets and occasionally, scurvy. The outpost stations refer their acutely ill patients, and send for surgery those with congenital abnormalities such as strabismus, harelip, cleft palate, dysplasia of hips and heart diseases. We refer the heart surgery and radium therapy patients to the University Hospital and the Cancer Clinic.

Some of the children are in hospital for long periods. Those who are of school age receive formal education while there. Patients who are ambulatory go to a classroom each weekday. Others are able to sit at tables in their rooms for short periods. The majority remain in their beds while the teacher instructs from a central point in the room or does individual teaching.

Play

Play is supervised. An outside play area is available during the summer months for each of the wards. Service clubs and other organizations help to provide entertainment and toys for both indoor and outdoor play. There are sandpits, slides, teeter-totters, swings, small-sized lawn chairs, tricycles, wagons, pull toys, rocking horses and even a wading pool in one play area. In the wintertime or on rainy days, play is restricted to indoors. A variety of toys is available — tricycles, pull toys, rocking horses and pedal cars are brought in; jolly jumpers, books, crayons and blackboards are brought out; last year's Christmas cards are again perused. Television is very popular with the three to five year-olds, and they sit in rapt attention during the children's programs. Some are as familiar with Roy Rogers, Howdy Doody and Huckleberry Hound as with each other's names. It is not uncommon to find a 5-year-old Eskimo complaining because he has to be a white man when he wants to be an Indian in their play wars. To the northern children, all animals on television are dogs. Sunday morning finds the play areas quiet as all the ambulatory children have dressed up and gone to church in one or other of the hospital chapels.

The inactive children are provided with numerous suitable toys and games on the ward. They are visited frequently by members of various organizations as well as by staff. A true affection develops between the children and regular visitors. A rocking chair, placed in

(Ernest of Goertz, Edmonton)

WINIFRED ROSCOE

(National Film Board of Canada)

Indian and Eskimo children, Charles Camsell Hospital, Edmonton

the ward for the nurse to use when attempting to solace a fretful child — sometimes one who is just getting used to a new and strange environment — helps to heal many breaks in small hearts.

Children who are old enough attend the annual Exhibition Parade in July. They also go to the patient's annual picnic held in Victoria Park. They visit the Shrine Circus and the Storyland Valley Zoo (Edmonton's Children's Zoo). Following such adventures as these, little else is spoken of or thought about for many days.

Christmas is especially pleasant. The children delight in helping to decorate the small trees which stand in each ward. Dancing schools present concerts and service clubs give gifts and parties. Some of the Indian bands contribute money to help fill Santa's bag before he arrives on Christmas Eve bearing a gift for every child. Christmas dinner is served with all the trimmings. Those who are well enough are taken by car to see the homes decorated for the holiday season. Children who are unable to return home for long periods are photographed. Personalized letters from the nursing and medical staff are sent to the parents along with the photograph.

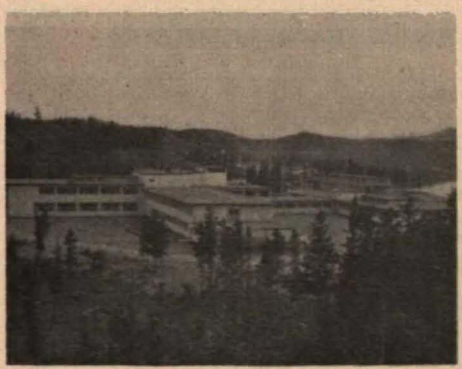
In addition to specific treatment, rest, play and nourishing food, the children receive basic necessities of all children everywhere. They are given, and they give, love and affection. They are disciplined to the degree that they are helped to understand the difference between right and wrong. Their minds and hands are kept occupied. They learn to get along with both children and adults.

When the time come to go home, clothing is carefully checked, diets written out, and medical reports sent to the doctor or nurse in the area who knows the family. A stuffed toy or favorite doll accompanies each child who, with his escort, goes home or to the closest hostel or nursing station — there to join his family.

Many of the children from the near-

by reserves are admitted repeatedly and become very well known to the staff. They begin they lives in our newborn nursery and we follow their growth and development thereafter. The staff becomes very attached to them. We endeavor to select personnel who are genuinely fond of children. The pediatric medical consultant, the ward doctors, the social worker and nursing staff, comprise an efficient group who work in a happy and relaxed atmosphere.

Whitehorse General Hospital, Yukon Territory



(National Film Board of Canada)

This hospital, combining the former Military and General Hospitals, was opened in 1959. It seems like a dream to think of the chaos that reigned behind the scenes for the first few days. We were faced with the problem of taking over patients and equipment from the two existing hospitals. It was almost the story of the chicken and the egg : we needed the equipment before we could take the patients and, of course, the old hospitals could not keep the patients without the equipment. Finally, we merged with excellent cooperation from all concerned. The hospital has a capacity of 120 beds and serves a city of 6,000 people comprised of Indians, military service personnel and other Canadian residents. It also serves the larger sparsely settled portion of the Territory.

The Yukon is the land of the famous Gold Rush. While that is long since past, its spell will linger on as long as the colorful old timers and their descendants remain to regale us with the fabulous, and ofttimes tragic tales of that era. No less adventurous than the past, the future of Whitehorse holds much of interest. Already it is an up-to-date community. It has a well organized local government, an excellent business centre, well-planned housing projects, and several new modern schools.

The hospital, under the direction of a Medical Superintendent, and with a staff of seven doctors (military and civilian) and component services, is solid testimony to the well-laid plans of Yukonites for the future.

Nursing on Top of the World

Who Serves ?

A small group of nurses located in outpost nursing stations strung across the Arctic in the shadows of the famous DEW Line sites. Three of these stations are located at Tuktoyaktuk, Coppermine and Cambridge Bay. Another group is strung out along the Mackenzie River, from the 60th parallel to Inuvik. There is a new station at Fort Liard in the beautiful Liard Valley.

Whom Do They Serve?

All citizens of unorganized communities in the Northwest Territories may receive care and public health services under Northern Health Services. Every individual who can be reached may be supervised for his lifetime. All members of each family from the infant to the grandparent are included in the program.

How Do They Serve?

By carrying out a generalized comprehensive program of health care. Prenatal and postnatal care and child health conferences are held wherever it is possible. An active school health program insures that every child has the benefit of up-to-date immunization against preventable diseases, and early detection and correction of defects. Contact and follow-up services in tuberculosis and venereal disease comprise an important aspect of the work.

Although the Indian and Northern Health Services nurse may be the only nurse in a community, she does not work alone. Somewhere in her area, within reach by radio or telephone, are a medical officer and a supervisor of

nursing ready to advise and support her in her efforts. Because other government and missionary agencies are responsible for social and spiritual welfare, the nurses work closely with these agencies in helping to solve family or individual problems related to health.

Inuvik General Hospital, Northwest Territories

At Inuvik, the new town of the Western Arctic, a new modern hospital is in operation. It is difficult to imagine facilities for health, education and community living such as are found at Inuvik, in the frozen north. They would compare favorably with any new residential section of a southern city. The 80-bed hospital cares for medical, surgical, obstetrical and pediatric patients. It also has a section for the treatment of tuberculosis patients. Modern equipment is provided to facilitate high quality patient care. A public health nurse who has her headquarters at the hospital carries out a generalized public health nursing program in the town and surrounding area.

Here the young nurse may enjoy working in her chosen profession with a group of citizens who, because of their way of life, present a special challenge. At the same time she is able to enjoy the conveniences of a modern hospital and community.

About Books

Dimensions of Professional Nursing by Cordelia W. Kelly, B.S., R.N. 485 pages. The Macmillan Company, 60 50th Ave., New York 11. 1962.
Reviewed by Catherine Slack, R.R. 3, Brockville, Ont.

In reviewing this text I turned first to the section "Professional Nursing in Canada" by M. Pearl Stiver. As a student, I would be proud of our nursing origin in Canada, and would derive inspiration from the example set by the picture on page 307. As a graduate it left me with the desire to maintain and "add to" the progress of this profession in Canada. I believe, however, that stress might have been placed on the fact that the graduate nurse has an obligation to participate in professional organizations; that she must increase her level of learning whether by formal preparation or daily practice.

I was impressed by Sections II and III, pages 42-119, "The Nurse as an Individual" and "Communications." These areas of adjustment for today's nursing student seem *most* difficult. It is interesting to note that the junior students of my hospital found the section on "Spiritual Care" a good reference.

As an instructor, I believe that this text is an excellent reference for professional adjustment courses.

The author has definitely completed her book's content with "two goals in mind: its immediate usefulness to the student nurse; and, its potential value as a reference for the graduate nurse."

The Facts of Mental Health and Illness by K. R. Stallworthy, M.B., Ch.B., Diploma Psychological Medicine. 227 pages. N. M. Peryer Ltd., 93-95 Cambridge Terrace, Christchurch, New Zealand. Ed. 3. 1961.

The aim of this text is "to give to the interested layman an account, in words he can understand, of the mind and of what may affect it."

This edition includes a chapter on the psychology of the physically ill and of those who care for them.

The Middle Years by Albert Sharman, M.D. 71 pages. The Macmillan Company of Canada Limited., 70 Bond Street, Toronto. 1962.

"The objects of this book are to give an account of the whole subject of the menopause and the 'change of life' in language which should be easily understood by women of reasonable intelligence and education."

Practical Nutrition by Alice B. Peyton, B.S., M.S. 434 pages. J. B. Lippincott Company, 4865 Western Ave., Montreal. Ed. 2. 1962.

This book has been written primarily for the practical nursing student. It gives a

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How to Determine Nursing Expenditures in Small Health Agencies by Marion Ferguson, R.N., Ph.D. 30 pages. United States Department of Health, Education, and Welfare. 1962.

The material in this publication has been developed by the Public Health Service and the National League for Nursing.

Aids to Surgical Nursing by Katharine F. Armstrong, M.A., S.R.N., S.C.M., S.T.D., and Norma Jamieson, M.A., S.R.N., S.C.M., S.T.D. 7th ed. 504 pages. The Macmillan Company of Canada Limited, 70 Bond Street, Toronto. 1961.

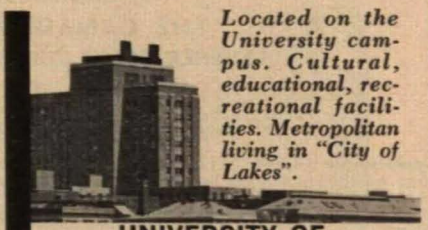
This edition includes a new chapter on the surgery of blood vessels, and revision of sections concerning inflammation and sepsis, chemotherapy, shock, sterilization, infusions and transfusion, surgery of the esophagus and thorax.

An illustration of postoperative positioning of the patient might be questioned by nurses in Canada.

Teen Home Nursing Manual prepared by The Canadian Junior Red Cross of The Canadian Red Cross Society, Toronto 5. Canada. 198 pages. 1962.

This attractive manual has been prepared to "Help young Canadians prepare themselves to assume a measure of responsibility for the better welfare of their own families and of the community at large."

The contents include: A discussion of the importance of mental and physical health to the individual; basic care of a sick person in the home; helpful information for baby sitters; principles of first aid.



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Logic of Operating Room Nursing by Jacqueline Willingham, R.N. 93 pages. Springer Publishing Co., Inc., New York. 1962.

This book is written for the information of the graduate nurse, the nursing student and the surgical technical aide. The author emphasizes *principles* rather than *details* of operating room nursing.

Content includes: Prevention of infections; prevention of explosions; information regarding equipment, admission of the patient to the operating room suite, positioning of patient, draping, and care of specimens.

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Matron for 39-bed hospital situated on main highway and C.P.R. line, full bus schedule. Fine modern busy town in central Alberta. Applications invited. Reply to: A. W. Smith, Secretary-Treasurer, Municipal Hospital, Innisfail, Alberta. 1-49-1

Registered Nurses for modern 20-bed hospital, commencing salary $350 per mo., accommodation and board $35.50. Recently renovated nurses' residence. Apply: Matron, Municipal Hospital, Myrnam, Alberta. 1-66-1

Registered Nurses for busy 44-bed active treatment hospital. Salary: $325 per mo. with bi-yearly increments. Excellent accommodation in recently opened nurses' residence. Medical and Hospitalization Group Plans. Liberal Holiday and sick schedule. Apply: Holy Cross Hospital, Box 339, Spirit River, Alberta. 1-81-1

Registered Nurses (immediately) for 54-bed hospital. Basic salary $300/m with 3 annual increments to $345, increment adjusted to previous experience. Group medical, hospitalization and pension plan. 40-hr. wk., 31 days' vacation after one year, accommodation in residence $35. Apply: Director of Nursing, Municipal Hospital, Vermilion, Alberta. 1-90-2

Registered Nurses (2) for active 35-bed hospital in progressive town (1,100 pop.) on paved highway 80-mi. east of Edmonton, Basic salary $325/m with 3 annual increments to max. $370. Full recognition of past service taken into account when determining starting salary. Board and room $30/m, excellent working conditions. Write or phone collect, Administrator, Municipal Hospital, Viking, Alberta. 1-91-1

Registered Nurses & Certified Nursing Aides (immediately) for new 70-bed hospital. Salary $325 - $370; $200 - $240; 40-hr. wk., liberal personnel policies, experience considered. Apply: Sister Superior, Providence Hospital, **HIGH PRAIRIE**, Alberta. 1-45-1

Graduate Nurses for 50-bed hospital. Salaries $300 to $345 commensurate with experience, less $35 for full maintenance. Apply: Mrs. E. Harvie, R.N., Matron, Lacombe Hospital, Lacombe, Alberta. 1-54-1

General Duty Nurses for well-equipped 76-bed hospital in active town of 3,000. Salary $300-$350 for Alberta registered; $290-$340 for non Alberta registered. New separate residence, excellent personnel policies & working conditions. Apply to: Director of Nursing, Brooks General Hospital, Brooks, Alberta. 1-13-1

General Duty Nurses. Starting salary: $300 per mo., 40 hr. work wk. Room, board & laundry, if desired, at nominal rates. Civil Service holiday, sick leave & pension benefits. Apply to: Baker Memorial Sanatorium, Dept. of Public Health, Calgary, Alberta. 1-14-3

NURSES fully qualified for 30-bed active treatment hospital. **New hospital building & recently renovated** nurses' residence. Unless definitely interested in coming, please do not apply. **Personnel policies sent upon** request. Apply to: Mrs. M. Hislop, Superintendent, Municipal Hospital, Bassano, Alberta. 1-5-1

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Information on these and other positions is available from Medical Services Directorate, Department of National Health and Welfare, in Vancouver, Edmonton, Regina, Winnipeg, Ottawa and Quebec, or from the

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General Duty Nurses and Operating Room Nurses with postgraduate course or equivalent experience required for 146-bed General Hospital. Personnel policies in accordance with RNABC. Apply: Director of Nursing, General Hospital, Chilliwack, British Columbia. 2-13-1

General Duty Nurses for 23-bed hospital on Sunshine Coast, 50-mi. from Vancouver. Salary $305 for graduates, $320 registered. Comfortable residence, health plan, superannuation. Apply to: The Administrator, St. Mary's Hospital, Garden Bay, British Columbia. 2-25-2

General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary range $320 to $387. Preplanned shift rotation, B.C. registration essential, 4-wk. vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia. 2-32-1

General Duty Nurses for 82-bed hospital in Northwestern B.C., 1963 salaries B.C. registered $335-$402; non-registered $320, room & board $50 per mo., 10 statutory holidays, 1½ days sick leave, 4-wk. vacation, superannuation & medical plan coverage, fare advanced if required. Apply to: Director of Nursing, General Hospital, Kitimat, British Columbia. 2-36-1

General Duty Nurses for 40-bed hospital. Salary for B.C. Registered Nurses $320-$387 & $305 for non B.C. Registered. Nurses' residence available. Apply: Director of Nursing, Nicola Valley General Hospital, Merritt, British Columbia. 2-41-1

General Duty Nurses for 110-bed hospital in northwestern B.C. Salary: non-registered $309, B.C. registered $324-$389. Travel allowance, newly furnished residence available. For full details contact: Director of Nursing, General Hospital, Prince Rupert, British Columbia. 2-58-2

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Nurses (2) for General Duty from January 1st in 17-bed acute hospital on the west coast of Vancouver Island. Salaries according to RNABC agreements & RNABC personnel policies in effect. Room & board in modern nurses' residence: $40 per mo. Apply by mail or telephone: Matron, General Hospital, Tofino, V.I., British Columbia. 2-71-1

General Duty, Operating Room & Experienced Obstetrical Nurses for 434-bed hospital with school of nursing. Salary: $320-$387. Credit for past experience & postgraduate training. 40-hr. wk. Statutory holidays. Annual increments; cumulative sick leave; pension plan; 28-days annual vacation; B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia. 2-73-13

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Graduate Nurses and Certified Nursing Assistants for 70-bed acute General Hospital on Pacific Coast. Salary for B.C. registered $309 with regular increments; unregistered $294; Nursing Assistants $205-$225. Board and room $25 per mo., 28-day vacation plus 10 statutory holidays after 1 year. Superannuation and medical plans. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia. 2-2-1

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic rate $320/m with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia. 2-9-1

Nurses two for 30-bed hospital. Salaries as per B.C. Registered Nurses' agreement. Comfortable nurses' home. Apply to: Miss H. Campbell, R.N., Director of Nursing, Community Hospital, Grand Forks, British Columbia. 2-27-1

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General Duty Nurses (3) for new 85-bed hospital. Good salary and generous personnel policies. Apply: Director of Nursing, Portage Hospital District No. 18, Portage La Prairie, Manitoba. 3-45-1

General Duty Registered Nurses for 62-bed General Hospital in a progressive community in north western Manitoba. Building project in planning stage. Salary $310-$360 from January 1, 1963. Resident accommodation available. For further particulars please contact: Miss E. R. Shacklady, Director of Nurses, Swan River Hospital, Swan River, Manitoba. 3-62-1

Graduate Nurses (4 or more immediately). Basic salary: $305 plus allowance for past experience. $5.00 increments every 6 mo. Separate residence with room and board available at $45 per mo. Free laundry of uniforms. Group insurance available. Apply: The Administrator, or, The Matron, The Altona Hospital District No. 24, P.O. Box 600, Altona, Manitoba. 3-1-1

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Director of Nursing. (Canadian Red Cross Society, Nova Scotia Division), required until September 1st, 1964. Duties include organization of home nursing courses and sickroom loan service which will require travelling throughout Nova Scotia. All employment benefits available. Complete job analysis prepared. Salary: negotiable. Apply: Mr. C. L. Illsley, Commissioner, Canadian Red Cross Society, 5257 Morris Street, Halifax, Nova Scotia. — TELEPHONE 423-7176. 6-17-9

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Registered Nurses for 100-bed General Hospital, salary $340 with four $10 increments, OHA pension plan in effect, good personnel policies, accommodation in residence if desired. For particulars apply to: The Director of Nurses, Lady Minto Hospital, Cochrane, Ontario. 7-30-1

Registered Nurses for 34-bed hospital, min. salary $340, 3-wk. vacation with pay, sick leave after 6-mo. service. **All staff** — 5-day 40-hr. wk., 9 statutory holidays, pension plan & other benefits. Apply to: Superintendent, Englehart & District Hospital, Englehart, Ontario. 7-40-1

Registered Nurses. Applications and enquiries are invited for general duty positions on the staff of the Manitouwadge General Hospital. Excellent salary and fringe benefits. Liberal policies regarding accommodation and vacation. Modern well-equipped 33-bed hopsital in new mining town, about 250-mi. east of Port Arthur and north-west of White River, Ontario. Pop. 3,000. Nurses' residence comprises individual self-contained apts. Apply, stating qualifications, experience, age, marital status, phone number etc. to the Administrator, General Hospital, Manitouwadge, Ontario. Phone: TAylor 6-3251. 7-74-1

Registered Nurse for General Duty for 48-bed hospital in growing community. Excellent fringe benefits and liberal starting salary. Less than ½-hr. from well known winter and summer resorts. Apply : Director of Nursing, Memorial Hospital, Hanover, Ontario. 7-56-1

Rgeistered Nurses, general floor duty, rotating shifts. Modern residence accommodation. Basic salary: $350 with 6 monthly increments for 2 yrs. Room and board (maintenance) $45. Apply to : Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario. 7-29-1

Registered or Graduate Nurses for modern 100-bed hospital located in summer resort district, 40-mi. from Ottawa. Apply: Director of Nursing, Public Hospital, Smiths Falls, Ontario. 7-120-2

Registered Nurses and Certified Nursing Assistants for modern 64-bed General Hospital. Apply to: Director of Nursing, Arnprior and District Memorial Hospital, Arnprior, Ontario. 7-4-1

Registered Nurses & Certified Nursing Assistants for modern 75-bed hospital. Starting salaries — R.N.'S $310 per mo., C.N.A.'S $220 per mo. Single room accommodation available in the residence. Dryden (population 6,500) an industrial town, also center of extreme tourist area, is conveniently located midway between Winnipeg & the Canadian Lakehead. For further information regarding personnel policies, community activities, etc. please call or write: The Director of Nursing, Dryden District General Hospital, Dryden, Ontario. 7-36-1

Registered Nurses & Certified Nursing Assistants for 160-bed accredited hospital. Starting salary $340 and $235 respectively with regular annual increments for both. Excellent personnel policies. Residence accommodation available. Assistance with transportation can be arranged. Apply to : Director of Nursing, Kirkland & District Hospital, Kirkland Lake, Ontario. 7-67-1

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Registered Nurses for General Duty in modern 18-bed Private Hospital in iron mining town, 140 miles north of Sault Ste. Marie, Ontario. Starting salary $310 min. to $360 max., less $20 per mo. maintenance. Recognition for experience up to 3 years. Good accommodations & personnel policies. Transportation allowance after 6-mo. **Operating Room Nurse** starting salary $364 min. with postgraduate course to $414 max. with recognition for experience. Apply: Superintendent of Nurses, Lady Dunn Hospital, Wawa, Ontario. 7-140-1

General Duty Nurses for an accredited 66-bed hospital. Starting salary: $325. Excellent personnel policies, pension plan, residence accommodation only 10 min. from downtown Buffalo. Apply: Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario. 7-45-1

General Duty Nurses for new 70-bed hospital in Muskoka District. Starting salary $305/m., good personnel policies. Apply: Director of Nursing, Huntsville District Memorial Hospital, Huntsville, Ontario. 7-59-1

General Duty Nurses for modern 100-bed hospital. Registered Nurses $315-$345 per mo., Graduates $250-$295; 40-hr. wk., benefits include accident, sickness and life insurance, hospital and medical insurance plans, & OHA Pension Plan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario. 7-69-1

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Operating Room Nurse for modern 75-bed General Hospital, good personnel policies with consideration for past experience. For complete information, please write, wire or telephone to: The Director of Nursing, Dryden District General Hospital, Dryden, Ontario. 7-36-1A

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, ear, eye, nose and throat, and orthopedic surgery. Good salary and personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario. 7-73-10

Public Health Nurses (qualified) Salary $3,900 to $4,900, annual increment $200, car provided or car allowance. Apply to: Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Box 337, Cobourg, Ontario. 7-28-4

Public Health Nurse(s) (Qualified) for a generalized program in Etobicoke Township. Minimum salary $4,045, car allowance $670/annum, 4-wk. vacation after one year. The usual employee benefits. Apply: Director of Public Health Nursing, Township of Etobicoke, 550 Burnhamthorpe Road, Etobicoke, Ontario. 7-41-2

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Public Health Nurses (qualified) for generalized nursing service. Salary range: $3,800-$4,750 based on experience. Apply to: Dr. J. M. McGarry, M.O.H. St-Catharines-Lincoln Health Unit, St. Catharines, Ontario. 7-111-4

Public Health Nurses for generalized program, salary range $3,920-$4,760 (minimum based on experience). Good personnel policies, 3-wk. vacation, accumulative sick leave, pension plan and other benefits. Apply to: Dr. J. Howie, Director, Metropolitan Windsor Health Unit, 2090 Wyandotte Street East, Windsor, Ontario. 7-145-8

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Registered Nurses immediate openings in modern 300-bed hospital building. Starting salary $365/m., 5-day 40-hr. wk., liberal vacation and fringe benefits, paid insurances, cafeteria. Contact: Mrs. Dorothea Stuart, Personnel Director, Fresno Community Hospital, Fresno 15, California. 15-5-17

Registered Nurse for private practice in Southern California. Starting salary $365. Must report for work no later than May 1, 1963. Contact: Mrs. Martin, 390 S. Marie, La Habra, California. 15-5-18

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Registered Nurses for modern 125-bed General Hospital in friendly, scenic California town. Starting salary for Staff Nurses $375, liberal shift and specialties differential, 40-hr.wk., no shift rotation, excellent fringe benefits. New Pediatric Unit. Apply: Personnel Department, Mercy Hospital, Redding, California. 15-5-27

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Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Starting salary $375 per mo. plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California. 15-5-39

General Duty Staff Nurses for large General Hospital, located in college community, central California. Starting salary: $413 per mo. Excellent in-service education program, liberal fringe benefits, shift differential. Apply: Personnel Director, 530 Courthouse, Stockton, California. 15-5-36

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Staff Duty positions (Nurses) in private 428-bed hospital. Liberal personnel policies and salary. Differential for evening and night duty. Write: Personnel Director, Hospital of The Good Samaritan, 1212 Shatto Street, Los Angeles 17, California. 15-5-3B

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Nurses for new 75-bed General Hospital. Resort area. Ideal climate. On beautiful Pacific ocean. Apply to: Director of Nurses, South Coast Community Hospital, South Laguna, California. 15-5-50

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Registered Nurses for 74-bed air-conditioned hospital, growing community. Starting salary: $330 per mo., fringe benefits, vacation, sick leave, holidays, life insurance, hospital insurance, 1 meal furnished. Write: Hendry General Hospital, Clewiston, Florida. 15-10-1

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Staff Nurses for modern 400-bed tuberculosis hospital, suburban Cleveland, Ohio. Monthly salaries start at $396 with semi-annual increments. Extra for night and relief duty, 5-day work wk., 3-wk. paid vacation, 6 paid holidays, liberal sick leave, comfortable accommodations in nurses' residence at low rate. Learn and earn at a progressive accredited hospital in a growing community. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio. 15-36-1E

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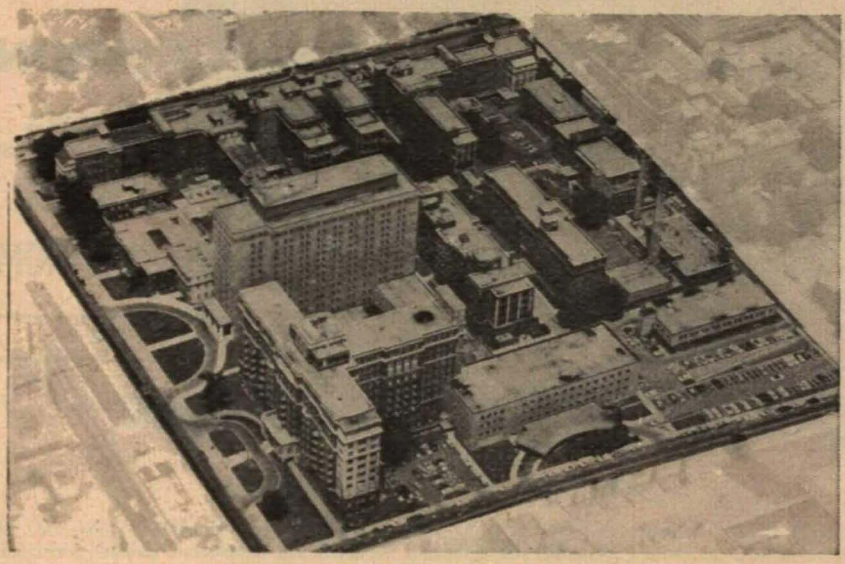

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Registered Nurse (immediately) for Union Hospital, Mossbank, Sask., with Dr. J. T. Stockings in attendance, salaries as per SRNA with increments and benefits. 40-hr. wk., fully modern nurses' residence, daily bus service to the city. Apply to: Mrs. A. Haug, Matron, Mossbank, Saskatchewan. 10-88-1

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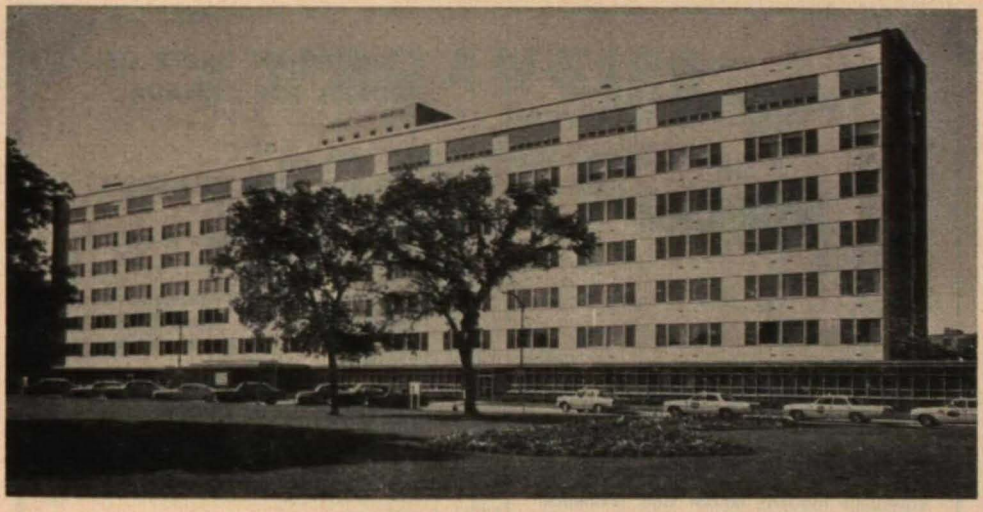

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General Duty Nurses for Obstetrics and Operating Room in new 188-bed Regional Hospital on Vancouver Island opening In January, 1963.

Salary: General Duty R.N. $320 to $387.

Allowance for experience and postgraduate education.

Personnel policies in accordance with RNABC includes Statutory Holidays, 20 days Vacation, Sick Leave, Medical Plan and Pension Fund.

Apply to:

DIRECTOR OF NURSING

Nanaimo Regional General Hospital

Nanaimo, B.C.

TWO OPENINGS

for the position of

INSTRUCTOR

for July 1, 1963, one to teach basic sciences.

Certificate in Nursing Education required. Additional Salary for Degree. One Class per year registers in September. Well-equipped modern school and residence.

Apply:

DIRECTOR OF NURSING

GENERAL HOSPITAL

Guelph, Ontario

VICTORIAN ORDER OF NURSES FOR CANADA . . .

requires

PUBLIC HEALTH NURSES

for Staff and Supervisory positions in various parts of Canada.

Applications will be considered from Registered Nurses without Public Health training but with University entrance qualifications.

SALARY, STATUS AND PROMOTIONS ARE DETERMINED IN RELATION TO THE QUALIFICATIONS OF THE APPLICANT.

Apply to:

DIRECTOR IN CHIEF

VICTORIAN ORDER OF NURSES FOR CANADA

5 BLACKBURN AVENUE

Ottawa 2, Ont.

THE PROVINCE OF MANITOBA

requires a

DIRECTOR OF INSTITUTIONAL NURSING SERVICES

for the

SELKIRK HOSPITAL FOR MENTAL DISEASES

This is the senior nursing position in a large hospital, for treatment of Mental Diseases and the incumbent is responsible for the over-all supervision of nursing services, including teaching and community services and the formulation or nursing policy and procedure under the general direction of the Medical Superintendent.

Applicants must be qualified to practise as a Registered and Psychiatric Nurse in Manitoba and must have a high level of demonstrated proficiency in planning and administrative procedures, directing program of nursing care, and supervising personnel. Preference will be given to applicants with a University degree in Nursing and supervisory nursing experience.

Salary Range : $5,040 - $6,240 per annum.

Applicants with lesser qcalifications will be given consideration; and assistance through bursary may be provided for postgraduate training following a period of employment.

Full Civil Service benefits including liberal sick leave with pay, three weeks' vacation with pay, pension privileges and group insurance.

Apply to :

MANITOBA CIVIL SERVICE COMMISSION

Room 332 Legislative Building, Winnipeg 1, Manitoba.

VACANCIES

CIVIL SERVICE OF NEW BRUNSWICK

DEPARTMENT OF HEALTH

(Both English speaking and Bilingual)

PUBLIC HEALTH NURSES :

Graduation from an approved school of nursing, supplemented by completion of an approved postgraduate program of study in public health nursing; or equivalent. Certification or eligible for certification as a Registered Nurse in New Brunswick. Comp. No. N.B. 63-20

SALARY : $3,336 - $4,056 PER ANNUM

PSYCHIATRIC NURSES :

(Provincial Mental Hospitals located in Campbelton and Lancaster)

Graduation from an approved school of nursing, supplemented by courses in psychiatric nursing, and some experience in the nursing of the mentally ill; or equivalent. Certification or eligible for certification as a Registered Nurse in New Brunswick **OR** graduation from a recognized school of psychiatric nursing. Comp. No. N.B. 63-21

SALARY: $3,336—$4,056 PER ANNUM

NOTE :

Nurses without training or equivalent experience in the public health or psychiatric nursing fields will be paid $3,024 per annum for a period of one year while receiving experience in the field.

ASSISTANT NURSE CONSULTANT :

to provide consultative nursing services to hospitals throughout the Province, graduation from an approved school of nursing, and considerable responsible supervisory nursing experience. Certification or eligible for certification as a Registered Nurse in New Brunswick. Salary $4,056 - $4,944 per annum. Comp. No. N.B. 63-22

ANNUAL INCREMENTS OF 5 PER CENT — FULL CIVIL SERVICE BENEFITS

Apply :

CIVIL SERVICE COMMISSION

P. O. Box 1055, Fredericton, N. B.

GENERAL DUTY NURSES FOR ALL DEPARTMENTS

Gross salary $325 monthly with annual increments for 4 years to $365.

Until registration in Ontario is established — $300.

Rotating periods of duty — 40 hour week, 8 statutory holidays annually — Annual vacation 21 days after one year.

Annual sick time 12 days after one year, unused portion cumulative to 36 days.

Hospitals of Ontario Pension Plan.

Ontario Hospital Insurance and Physicians' Services Incorporated, 50% payment by hospital.

Apply:

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO

THE SARNIA GENERAL HOSPITAL

Offers excellent opportunities for

REGISTERED NURSES AND CERTIFIED NURSING ASSISTANTS

Sarnia is a rapidly growing city located midway on the seaway, 60 miles north of Detroit and Windsor and 60 miles west of London. It is a summer resort area noted for swimming and boating as well as being located a reasonable distance from the skiing resorts in Northern Michigan.

The Hospital is modern, fully approved (JCAH) with a new wing to be completed in July 1963.

Positions are available in all services.

Salary scale with annual increments to the maximum. Benefits include pension plan, 40-hour week, regular rotation of shifts with premium pay for evenings and nights.

Apply to:

PERSONNEL DIRECTOR, SARNIA GENERAL HOSPITAL, SARNIA, ONTARIO

HUMBER MEMORIAL HOSPITAL

HOSPITAL —
Newly expanded 350-bed hospital. Progressive patient care concept.

SALARY —
1963 schedule General Staff Nurses $325-$375 per month and Certified Nursing Assistants $230-255 per mo.

HOUSING —
Furnished apartments available at subsidized rates.

JOB SATISFACTION —
High quality patient care and friendly working environment, personal recognition and professional development.

You are invited to enquire concerning employment opportunities to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL
200 Church Street, Weston, Ontario - Telephone 249-8111 (Toronto)

CORNWALL GENERAL HOSPITAL

requires immediately

OBSTETRICAL SUPERVISOR

for

new, well-equipped department in 225-bed hospital.

ALSO
EDUCATIONAL DIRECTOR AND INSTRUCTOR

required in July 1963

for progressive school of nursing approximately 65 students.

Attractive salary and personnel policies, 4 weeks annual vacation, insurance and pension plans.

Located in the heart of the Seaway vacation land, Cornwall is also within easy reach of Montreal and Ottawa.

For information, please write:

THE DIRECTOR OF NURSING
Cornwall General Hospital,
Cornwall, Ontario.

HAMILTON GENERAL HOSPITAL

GENERAL STAFF NURSES

required for

INTENSIVE CARE UNIT, SURGERY, MEDICINE, EMERGENCY DEPARTMENT AND OPERATING ROOMS.

For personnel policies and further information, apply to:

DIRECTOR OF NURSING
Hamilton General Hospital
Barton Street East
Hamilton, Ontario

GRADUATE STAFF NURSES

Opportunities for men and women on all services including metabolism, rehabilitation, psychiatry, recovery room, medicine, surgery, pediatrics, obstetrics, operating room, and emergency room. Well planned orientation and in-service programs, tuition-free courses at Western Reserve University after 3 months employment, low cost housing in nurses' residence. Liberal personnel policies with premium for evening and night tours of duty. Starting rate based on experience and enducation. Staff nurse salary range $385 to $425. Write for more information and the booklet "New Horizons in Nursing," to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITALS OF CLEVELAND

University Circle, Cleveland 6, Ohio

MONTREAL CHILDREN'S HOSPITAL

has vacancies for

1. **Registered Nurses and Certified Nursing Assistants**
   on various wards — Bilingual preferable but not necessarily.
2. **Operating Room Nurses with either postgraduate preparation or experience.**

Apply in writing to :

Director of Nursing
MONTREAL CHILDREN'S HOSPITAL
2300 Tupper Street, Montreal 25, Que.

ST. JOSEPH'S HOSPITAL

HAMILTON, ONTARIO

A modern, progressive, 850-bed hospital located in the centre of Ontario's Golden Horseshoe, has openings for :

1) Head Nurses for Medical or Surgical units. Postgraduate study preferred
2) General staff nurses in all clinical areas.
3) Certified Nursing Assistants in all clinical areas.

For further information write to :

THE DIRECTOR OF NURSING SERVICE
St. Joseph's Hospital, Hamilton, Ontario.

NURSES

If you desire to practise your profession in a modern and scientific hospital, that has 21 specialties and 1,050 beds, join the nursing staff of

NOTRE DAME HOSPITAL

Generous salaries, according to qualifications, with periodic increases. Differential for evening and night duty, 10 statutory holidays. Vacation based on date of employment. Pension plan. In-service education program. Recreational center

For information, write to:

LA DIRECTRICE DU NURSING
HOPITAL NOTRE-DAME, 1560 est, rue Sherbrooke, Montréal 24

REGISTERED NURSES

and

CERTIFIED NURSING ASSISTANTS

for

360-bed accredited General Hospital. Registered Nurses salary range $315-$355 per month with consideration for contemporary experience or special preparation.

Certified Nursing Assistants $210 - $240 per month.

For further information write:

Director of Nursing Service
METROPOLITAN GENERAL HOSPITAL
Windsor, Ontario.

CLINICAL INSTRUCTOR

in

Principles and Application of Operating Room Technique

Diploma in Nursing Education and experience in the O.R. preferred. Excellent opportunity for using progressive techniques in teaching.

Position open July 1963.

This 300-bed hospital has modern classrooms and facilities. New nurses' residence. Student enrollment - 94.

Apply :

Personnel Director
SARNIA GENERAL HOSPITAL
Sarnia, Ontario.

VICTORIA HOSPITAL

LONDON, ONTARIO

Modern 900-bed hospital

requires

Registered Nurses for all services

and

Certified Nursing Assistants

40 hour week - Pension plan - Good salaries and Personnel Policies.

Apply :

DIRECTOR OF NURSING
VICTORIA HOSPITAL, LONDON, ONT.

JOSEPH BRANT MEMORIAL HOSPITAL

BURLINGTON, ONTARIO

228-bed hospital

Progressive community of 50,000

Located near Toronto, Hamilton and the U.S. Border.

Positions are available for

GENERAL DUTY NURSES

For information, write to the

Director of Nursing

REGISTERED NURSES

wanted for

GENERAL DUTY

on Medical and Surgical Floor and Intensive Care Unit in 209-bed General Hospital. O.H.A. Pension Plan.

Stratford is a delightful city of 20,000 within easy reach of larger centers.

Basic Salary: $310, annual increments.

Please apply to :

DIRECTOR OF NURSING
Stratford General Hospital
Stratford, Ontario.

REGISTERED NURSES
and
CERTIFIED NURSING ASSISTANTS
required for

FIVE SUMMER CAMPS

STRATEGICALLY LOCATED
THROUGHOUT ONTARIO
AND NEAR
OTTAWA - LONDON
COLLINGWOOD
PORT COLBORNE
KIRKLAND LAKE

Apply in writing to:

MISS HELEN WALLACE, REG'D. N.

Supervisor of Camps
ONTARIO SOCIETY FOR CRIPPLED CHILDREN
350 Rumsey Road
P.O. Box 1700, Station "R"
Toronto 17, Ontario

PORT COLBORNE GENERAL HOSPITAL

PORT COLBORNE, ONTARIO

requires

REGISTERED NURSES

For expanding General Hospital 100 beds presently, increasing to 166. Hospital beautifully located on Lake Erie. Salary $325 per month with accompanying satisfactory personnel policies. Vacancies in the O.R., the Emergency Department and the Central Supply Room, as well as general wards.

Apply :

DIRECTOR OF NURSING

Operating Room Nurses

General Staff Nurse positions available in General Operating Rooms (general surgical, cardiac, neuro-surgical, plastic, orthopedic, ear, nose and throat, and urology). Positions also in Gynecological and Ophthalmological operating rooms. Salary commensurate with experience, excellent additional benefits including refund of tuition up to six points per semester.

For further information write to:

DIRECTOR, NURSING SERVICE
THE JOHNS HOPKINS HOSPITAL
BALTIMORE 5, MARYLAND

WOODSTOCK GENERAL HOSPITAL

WOODSTOCK, ONTARIO

requires

MEDICAL CLINICAL TEACHER

Preferably with B.Sc.N. degree and experience.
Salary commensurate with qualifications and experience.

Apply to:

DIRECTOR OF NURSING
WOODSTOCK GENERAL HOSPITAL, WOODSTOCK, ONTARIO.

REGISTERED NURSES AND LICENSED PRACTICAL NURSES

Accredited voluntary hospital. Brand new. Pleasant residential community 30 minutes from NYC, close to resort areas. Residence facilities. In-service training program. 40 hour week, sick benefits, paid vacation. Top salaries; added increments for education, training and experience.

Contact:

NURSING OFFICE,
NYACK HOSPITAL, NYACK, NEW YORK.

BROCKVILLE GENERAL HOSPITAL

BROCKVILLE, ONTARIO

SCHOOL OF NURSING

Invites applications for

TWO INSTRUCTORS

Requirements: University preparation in Nursing Education
Salary differential for degree

Apply to: **DIRECTOR OF NURSING**

OPERATING ROOM SUPERVISOR

Applications are invited from interested persons for the position of Operating Room Supervisor at the General Hospital, St. John's, Newfoundland.

A postgraduate course and experience is essential.

Duties to include overall direction of 12 room Operating Theatre plus a Recovery Room.

Fare paid to St. John's on the basis of a minimum of one year's service.

Applications or requests for further information should be sent to:

DIRECTOR OF NURSING
GENERAL HOSPITAL
ST. JOHN'S, NEWFOUNDLAND.

INSTRUCTORS

Required (August 1963) for

CITY HOSPITAL, SASKATOON, SASK.

(350 beds)

A nursing arts instructor and a clinical instructor in obstetrical nursing. Salary commensurate with preparation and experience. Liberal vacation with pay, cumulative sick leave, superannuation plan.

Apply :

DIRECTOR OF NURSING

QUEENSWAY GENERAL HOSPITAL

requires

REGISTERED NURSES
for Fall vacancies

Liberal personnel policies

Apply:

DIRECTOR OF NURSING
QUEENSWAY GENERAL HOSPITAL
Sherway Drive, Toronto 18, Ontario

REGISTERED NURSE

For

NURSE TECHNICIAN TEAM

(Intravenous Medication)

Hospitals of Ontario Pension Plan and Group Life Insurance, Shared Cost of P.S.I. and Hospital Insurance.

Apply :

ASSISTANT DIRECTOR (MEDICAL)
Ottawa Civic Hospital
Ottawa 3, Ontario.

BEULAH HOME

Invites applications for the position of

SUPERINTENDENT

QUALIFICATIONS : Registered Nurse and/or Social Service background. Genuine Christian concern for the needs of the unmarried mother — DUTIES : General supervision of 40-bed home for unmarried mothers.

Registered Nurse also needed.

Apply stating qualifications and experience to :

REV. A. E. KING, CHAIRMAN
Beulah Home Board of Directors
13340 - 101 Street, Edmonton, Alberta.

ASSISTANT DIRECTOR
OF
NURSING SERVICE

For accredited 325-bed hospital

Qualifications:
Baccalaureate Degree preferred
Supervisory experience
Salary according to qualifications

Apply to:

DIRECTOR OF NURSING
THE DOCTORS HOSPITAL
45 BRUNSWICK AVENUE
TORONTO 4, ONTARIO.

GENERAL STAFF NURSES

Required for

CLEARWATER LAKE HOSPITAL

The Pas, Manitoba

Interesting positions immediately available for hospital of 150-beds for tuberculosis (Indians and Eskimos) and extended treatment patients. Initial salary $325 per month.

Apply to:

Nursing Consultant

SANATORIUM BOARD OF MANITOBA

800 Sherbrook Street, Winnipeg 2, Manitoba.

GREY COUNTRY HEALTH UNIT

Will commence operation July 1st, 1963. Applications and enquiries regarding the position of a Supervisor of Public Health Nursing are invited. Please apply to the undersigned giving qualifications, experience, salary expected and date available.

H. J. HENDERSON
COUNTY CLERK-TREASURER, COUNTY COURT HOUSE, OWEN SOUND, ONTARIO.

PUBLIC HEALTH NURSES

REQUIRED FOR HEALTH BRANCH, B.C. CIVIL SERVICE

Positions available for qualified Public Health Nurses in various centres in British Columbia. SALARY: $356-$440 per month; car provided. An opportunity for interesting and challenging professional service in this beautiful and fast-developing Province. For further information and application forms, apply to The Director, Public Health Nursing, Department of Health Services and Hospital Insurance, Parliament Buildings, Victoria, B.C., or to The Chairman, B.C. Civil Service Commission, 544 Michigan Street, Victoria, B.C.

COMPETITION No. 62:57

CAMP DIRECTORS

Registered Nurses to direct summer camps for crippled children — June, July, August. Preference given to applicants with supervisory experience.

For further information apply to:

SUPERVISOR OF CAMPS
Ontario Society for Crippled Children,
Box 1700, Postal Station "R",
350 Rumsey Road, Toronto 17,
Ontario.

REGISTERED NURSES
and
CERTIFIED NURSING ASSISTANTS

are invited to enquire re: employment opportunities for all departments.
140-bed hospital. Good personnel policies, O.H.A. Pension Plan.

Enquire:

DIRECTOR OF NURSING
ROSS MEMORIAL HOSPITAL
Lindsay, Ontario

WOODSTOCK GENERAL HOSPITAL

REQUIRES

TWO GENERAL STAFF NURSES
for
OPERATING ROOM
Preferably with experience

For further information write:

DIRECTOR OF NURSING
WOODSTOCK GENERAL HOSPITAL
WOODSTOCK, ONTARIO.

"Summer Time is Sports Time" at the Lakehead

The McKellar General Hospital wants Registered Nurses and is willing to prepay costs of transportation for those nurses remaining on staff for one year. Basic salary for Registered Nurses — $325 per month. Good residence accommodation is available.
"The Hospital and the Community are friendly."

Apply to:

DIRECTOR OF NURSING
McKELLAR GENERAL HOSPITAL
FORT WILLIAM, ONTARIO.

OTTAWA CIVIC HOSPITAL

requires
GENERAL STAFF NURSES
for
OPERATING ROOM
MEDICAL
SURGICAL
OBSTETRICAL AND
PSYCHIATRIC
} DEPARTMENTS

Apply
EDITH G. YOUNG, REG. N.,
Assistant Director and Administrator of the Department of Nursing

REGISTERED NURSES

For general duty in 120-bed Radiotherapy Centre, affiliated with University of Toronto.

Please apply to:

Director of Nursing
Princess Margaret Hospital
500 Sherbourne St.
Toronto 5

REGISTERED NURSES
OPERATING ROOM NURSE
and
CERTIFIED NURSING ASSISTANTS

required for:
82-bed hospital. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates and personnel policies apply to:

DIRECTOR OF NURSING
HALDIMAND WAR MEMORIAL HOSPITAL
DUNNVILLE, ONTARIO

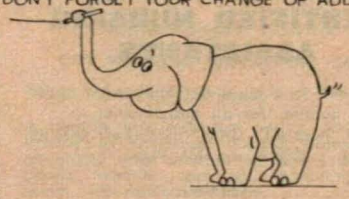
GENERAL DUTY NURSES

for
Chest Hospital in centre of Montreal
Good Personnel Policies

Apply:

DIRECTOR OF NURSING
ROYAL EDWARD LAURENTIAN HOSPITAL
3650 ST. URBAIN STREET
MONTREAL 18, QUE.

DON'T FORGET YOUR CHANGE OF ADDRESS···



REGISTRATION No. .....

PROVINCE .....

NAME .....

(Maiden name, if recently married)

OLD ADDRESS .....

.....

NEW ADDRESS .....

.....

DATE EFFECTIVE .....

Mail this to:
THE CANADIAN NURSE JOURNAL
1522 SHERBROOKE STREET WEST, MONTREAL 25, P.Q.

NOVA SCOTIA SANATORIUM

KENTVILLE, N.S.

Offers to Graduate Nurses a Three-Month Course in *Tuberculosis Nursing*, including Immunology, Prevention, Medical and Surgical Treatment.

1. Full series of lectures by Medical and Surgical staff.
2. Demonstrations and Clinics.
3. Experience in Thoracic Operating Room and Postoperative Unit.
4. Full maintenance, salary and all staff privileges.

For information apply to:

DIRECTOR OF NURSING
NOVA SCOTIA SANATORIUM
KENTVILLE, N.S.

CHILDREN'S HOSPITAL OF WASHINGTON, D.C.

OFFERS

Registered Nurses a 16-wk. supplementary program in pediatric nursing. Admission dates, January 2, May 7, September 4, 1962; January 7, 1963.

For complete information write to:

DIRECTOR OF NURSING
2125 - 13th STREET, N.W.,
WASHINGTON 9, D.C.

KEMPTVILLE DISTRICT HOSPITAL

requires

REGISTERED NURSES

for General Hospital located in attractive community one hour from downtown Ottawa. Good personnel policies, employer participation in pension plan and other benefits.

Apply:

SUPERINTENDENT
KEMPTVILLE DISTRICT HOSPITAL
KEMPTVILLE, ONTARIO

EDUCATIONAL OPPORTUNITIES

DALHOUSIE UNIVERSITY

School of Nursing

Degree Course in Basic Professional Nursing

Candidates for the degree of Bachelor of Nursing are required to complete 2 years of university work before entering the clinical field, and one year of university work following the basic clinical period of 30 months. On completion of the course the student receives the **Degree** of Bachelor of Nursing and the **Professional Diploma** in either Teaching in Schools of Nursing or Public Health Nursing.

Degree Course for Graduate Nurses

Graduate nurses who wish to obtain the degree of Bachelor of Nursing are required to complete the three years of university work.

Diploma Courses for Graduate Nurses

(a) Public Health Nursing
(b) Teaching in Schools of Nursing
(c) Nursing Service Administration

For further information apply to:

DIRECTOR, SCHOOL OF NURSING
DALHOUSIE UNIVERSITY, HALIFAX, N.S.

UNIVERSITY OF SASKATCHEWAN

SCHOOL OF NURSING

in cooperation with

UNIVERSITY HOSPITAL

PROGRAMS FOR GRADUATE NURSES

Teaching and Supervision. **To prepare for positions in teaching and supervision in Schools of Nursing.**

Public Health Nursing. **To prepare for staff positions in all types of public health nursing agencies.**

Administration of Hospital Nursing Service. **To prepare for head nurse, supervisor or matron positions in large or small hospitals.**

Credits earned may be applied toward the degree of Bachelor of Science in Nursing.

PROGRAMS FOR HIGH SCHOOL GRADUATES

Bachelor of Science in Nursing. **Students with senior matriculation may enroll in a combined academic and professional program.**

Diploma in Nursing. **The School also conducts a three-year hospital program.**

For further information apply to:

DIRECTOR, SCHOOL OF NURSING,
UNIVERSITY OF SASKATCHEWAN,
SASKATOON, SASKATCHEWAN

UNIVERSITY OF BRITISH COLUMBIA

School of Nursing

DEGREE COURSE IN BASIC NURSING

DEGREE COURSE FOR GRADUATE NURSES

Both of these courses lead to the B.S.N. degree. Graduates are prepared for public health as well as hospital nursing positions.

DIPLOMA COURSES FOR GRADUATE NURSES

1. **Public Health Nursing.**
2. **Administration of Hospital Nursing Units.**

For information write to:

The Director, SCHOOL OF NURSING
UNIVERSITY OF B.C.,
VANCOUVER 8, B.C.

ROYAL VICTORIA HOSPITAL

SCHOOL OF NURSING

MONTREAL, QUEBEC

Postgraduate Courses

1. (a) Six month clinical course in Obstetrical Nursing.

   Classes—September and February.

   (b) Two month clinical course in Gynecological Nursing.

   Classes following the six month course in Obstetrical Nursing.

   (c) Eight week course in Care of the Premature Infant.

---

2. Six month course in Operating Room Technique and Management.

   Classes—September and March.

---

3. Six month course in Theory and Practice in Psychiatric Nursing.

   Classes—September and March.

For information and details of the courses, apply to:—

Director of Nursing,
Royal Victoria Hospital
Montreal, P.Q.

THE WINNIPEG GENERAL HOSPITAL

Offers the following opportunity for advanced preparation to qualified Registered Graduate Nurses:

A six month Clinical Course

in

Operating Room Principles and Advanced Practice.

The course commences in September of each year. Maintenance is provided, and a reasonable stipend is given each month. Enrolment is limited to a maximum of ten students.

For further information please write to:

THE DIRECTOR OF NURSING

700 William Avenue, Winnipeg 2.

WILLS EYE HOSPITAL

Philadelphia, Penna.

The largest eye hospital in the United States offers a six-month course in *Nursing care of the Eye* to *Graduates of Accredited Nursing Schools*, Operating Room Training is scheduled in the course.

- **Full maintenance and a stipend of $237 per month for the first three months, $247 per month for the last three months, plus maintenance.**
- ***Registration Fee is* $20**
- **Course starts *September 16th* & *March 16th*. Ophthalmic Nurses in great demand for hospital eye departments, operating rooms & ophthalmologist's offices.**

For information write to:

Director of Nurses,
WILLS EYE HOSPITAL,
1601 Spring Garden Street,
Philadelphia 30, Penna.

SCHOOL FOR GRADUATE NURSES
McGILL UNIVERSITY

PROGRAMS FOR GRADUATE NURSES

DIPLOMA

Students are granted a diploma at the completion of the first year of the program leading to the degree of Bachelor of Nursing. All first-year students elect to study in

PUBLIC HEALTH NURSING

or

TEACHING AND SUPERVISION IN ONE OF THE FOLLOWING:

- Medical-Surgical Nursing
- Psychiatric Nursing
- Maternal and Child Health Nursing

DEGREE OF BACHELOR OF NURSING

A two-year program for nurses with McGill Senior Matriculation or its equivalent.

A three-year program for nurses with McGill Junior Matriculation or its equivalent. In the first year students elect a field as indicated above. In the final year students elect to major in one of the following:

- Nursing Education
- Administration and Supervision in Hospitals or in Public Health Agencies

DEGREE OF MASTER OF SCIENCE (APPLIED)

A program of approximately two years for nurses with a baccalaureate degree. Students elect to major in

- Development and Administration of Educational Programs in Nursing
- Nursing Service Administration in Hospitals and Public Health Agencies

PROGRAM IN BASIC NURSING

leading to the degree Bachelor of Science in Nursing

A five-year program for students with McGill Junior Matriculation or its equivalent. This program combines academic and professional courses with supervised nursing experience in the McGill teaching hospitals and selected health agencies. This broad background of education, followed by graduate professional experience, prepares nurses for advanced levels of service in hospitals and community.

For further information write to:

DIRECTOR, McGILL SCHOOL FOR GRADUATE NURSES

3506 UNIVERSITY STREET, MONTREAL 2, QUE.

UNIVERSITY OF TORONTO

SCHOOL OF NURSING — SESSION 1963-64

I BASIC DEGREE COURSE IN NURSING (B.Sc.N.)

Length : 4 years

This course provides study in nursing and in the sciences and humanities with practice in hospitals and health agencies. The course prepares for practice under the Nurses Registration Act of the Province of Ontario. Graduates are qualified for both public health and hospital nursing, and following experience are qualified for supervisory positions and for teaching in schools of nursing.

II DEGREE COURSE FOR GRADUATE NURSES (B.Sc.N.)

Length : 3 years

This course provides studies in the humanities, sciences and nursing. Applicants select a field of professional specialization such as Hospital Nursing Service, Nursing Education or Public Health Nursing.

III CERTIFICATE COURSES FOR GRADUATE NURSES

Length : 1 year

*Nursing Education
*Hospital Nursing Service
Public Health Nursing
Public Health Nursing — Advanced Course.

*Students who wish to take preparation in Psychiatric Nursing may register in Hospital Nursing Service or Nursing Education and include special work in Psychiatric Nursing.

For Calendar and Information concerning Bursaries and Scholarships apply to :

THE SECRETARY

UNIVERSITY OF TORONTO, SCHOOL OF NURSING, TORONTO 5, ONT.

QUEEN'S UNIVERSITY

SCHOOL OF NURSING

COURSES OFFERED

Undergraduate

Degree Course, B.N.Sc.,

Graduate Nurse

(a) Degree Course, two years.
(b) Diploma Courses, one year.
Public Health Nursing

Teaching and Supervision.

Entrance requirement for all courses: Senior Matriculation

For information apply to:

DIRECTOR
SCHOOL OF NURSING
QUEEN'S UNIVERSITY
Kingston, Ontario

A COURSE

in Advanced Operating Room Technique and Management

is offered by

THE MONTREAL GENERAL HOSPITAL

to

Qualified Registered Nurses

Classes of 6 months' duration are admitted March and September and are limited to 6 students.

For further information write to:

THE DIRECTOR OF NURSING
THE MONTREAL GENERAL HOSPITAL
MONTREAL 25, QUE.

CAREER ADVANCEMENT FOR NURSES

Nurses with advanced education for leadership are needed urgently throughout Canada.

Assumption University of Windsor offers special opportunities for

REGISTERED NURSES

1. Bachelor of Science in Nursing — two years
2. Diploma — one year

Professional courses include special emphasis on liberal education.

Residence Facilities — Gymnasium — Pool — Counselling Services

Apply to:

SCHOOL OF NURSING
ESSEX COLLEGE
Assumption University of Windsor,
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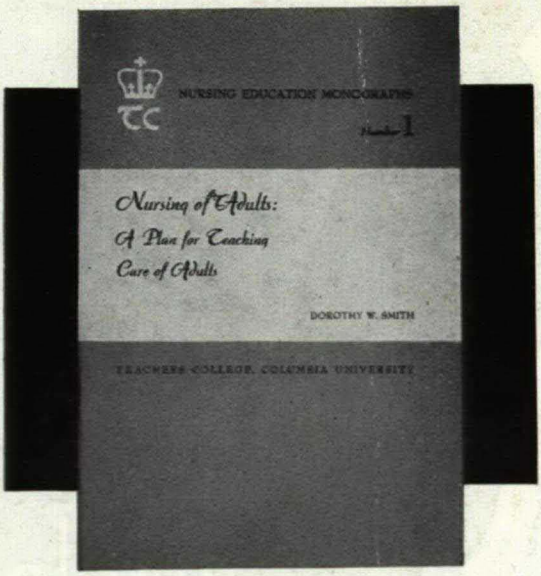

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(The author of this monograph, Dorothy W. Smith, R.N., Ed.D., Assistant Professor of Nursing, College of Nursing, Rutgers University, is currently preparing, with Claudia Gips., R.N., Ed.D., a textbook in medical-surgical nursing, to be published in mid-1963 by Lippincott.)

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